Reshaping Health Care in Latin America

A Comparative Analysis of Health Care Reform in Argentina, Brazil, and Mexico

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Contents

Foreword — *Maureen O'Neil* v
Preface vii

Section I. Introduction

Chapter 1. Reforming Health Care in Latin America: Challenges and Options — *Sonia Fleury* 3
  The Social Protection Model in Latin America 3
  After a Decade of Reforms in Latin America 7
  Some Issues in Comparative Analysis 12
  Methodological Options 20

Section II. Analysis of Health Care Policies

Chapter 2. The Context and Process of Health Care Reform in Argentina — *Susana Belmartino* 27
  Introduction 27
  Background Influences 29
  The Reform Process 31
  Implementation 35
  Reform of the Public Subsystem: Decentralization of the Hospital System 38
  Evaluation 40
  Conclusion 44
Chapter 3. Reorganizing the Health Care System in Argentina — *Susana Belmartino* 47
  Introduction 47
  Structural Features 47
  Transformations in the Health Service Systems — Organizational Models 59
  Health Service System Regulation 71
  Discussion 75
Chapter 4. The Context and Process of Health Care Reform in Brazil — *Lenaura Lobato and Luciene Burlandy* 79
  Introduction 79
  Background Influences 82
  The Reform Process 88
  The Reform Implementation 92
  Evaluation 98
  Conclusion 101
Chapter 5. Reorganizing the Health Care System in Brazil — *Lenaura Lobato* 103
  Introduction 103
  Structural Features 103
  Transformations in the Health Care System 115
  Conclusion 130
Chapter 6. The Context and Process of Health Care Reform in Mexico — *Silvia Tamez and Nancy Molina* 133
  Introduction 133
  Background Influences 135
  Reform Process 137
  Conclusions 150

Chapter 7. Reorganizing the Health Care System in Mexico — *Silvia Tamez and Nancy Molina* 153
Introduction 153
Structural Features 153
Changes in the Health Service System 169

Section III. Determinants of Utilization of Health Care Services

Chapter 8. A Population-based Survey in Three Cities of Latin America — *Enis Baris, Stella Sanchez, Mauricio de Vasconcellos, and Moises Balassiano* 185
Introduction 185
Determinants of the Use of Health Care Services in Argentina, Brazil and Mexico 192
Discussion 207
Appendix 1. Operational Definitions of the Variables in the Model 211
Appendix 2. Path Diagrams 213

Section IV. Conclusions

Chapter 9. Reshaping Health Care Systems in Latin America: Toward Fairness? — *Sonia Fleury* 225
Major Economic and Social Tendencies 225
The Health Reform Process 231
Comparative Analysis of the Health Care Reforms 238
The Make-up of a Reformed Health Care System 246
Lessons from the experience 256

Acronyms and Abbreviations 263

Contributing Authors 267

Bibliography 269

Foreword

This book assesses the health care reforms of the past decade in Argentina, Brazil and Mexico. The authors are in agreement that reform in the governance, management and financing of the provision of health services was essential.

However, they criticize the outcomes of the reform process not only for the anticipated exacerbation of social and economic inequalities, but also because of inattention paid to human resources as well as much-needed development of science and technology.

The country studies are set within the political and economic context of the reform period and strive to assess outcomes for people at different levels of income. The methodology illustrates the approach for which IDRC strives in the work it supports. IDRC operates on the belief that no "problem" — in this case accessible, affordable and appropriate health care — can be viewed in isolation from its context. As well, "solutions" must be judged by identifying exactly whose lives have improved.

Sadly, the ultimate conclusion of the researchers is not a hopeful one. The reforms are likely to leave many citizens with inadequate care and pit the middle class against the poor, both culturally and politically. Social solidarity will remain elusive. Indeed, if governments continue their implementation of reforms, the health sector could well be modernized without any reduction in the economic inequities fracturing the region.

This study should be a flashing red light to policymakers and the public: a signal to stop and confirm direction. Through their quality, accessibility and governance, health services demonstrate a democracy's effectiveness in meeting the critical needs of its citizens, just like education does.

Traditionally, the state in Latin America has been strong in its ability to control its citizens but not in creating the social solidarity (and services) that citizens need. Failure of the new democracies to strengthen the social state could have dire consequences. The reality is that so far, at least in the three countries studied, governments have not kept social fairness as the "bottom line" in the design of health reforms.

This study makes an important contribution to re-thinking policy directions. Its conclusions should inspire politicians and the public to take a second look.

Maureen O'Neil
President
International Development Research Centre

Preface

Since the early 1990s, several national and international research institutions and policy think-tanks in Latin America have been preoccupied with social sector reforms and their equity implications. This book draws on and expands earlier efforts with the overall goal of investigating in a comparative manner transformations in the modes of health care financing and delivery resulting from the last two decades of social reform in three Latin American countries — Argentina, Brazil and Mexico. Such earlier efforts included regional meetings organized by the Asociación Latinoamericana de Medicina Social (ALAMES, Latin American association of social medicine) and national or multi-country gatherings spearheaded by the Fundação Oswaldo Cruz (FIOCRUZ, Oswaldo Cruz foundation) and Fundação Getúlio Vargas (FGV) in Brazil, the Centro de Estudios Sanitarios y Sociales (CESS, centre for health and social studies) in Argentina, and the Universidad Autónoma Metropolitana – Xochimilco (UAM-X, autonomous university of Mexico – Xochimilco) in Mexico.

IDRC shared the preoccupations of these institutions and was willing to collaborate with FIOCRUZ, FGV, CESS, and UAM-X on a comparative research project that posed particular challenges from both a methodological and organizational point of view. First, comparability required the use of a similar underlying conceptual model, study design and methods of data collection. At the same time, an overly rigid approach had to be avoided to allow the specific characteristics of each country to emerge. Second, a balanced approach was needed to make best use of the strengths of both quantitative and qualitative methods of inquiry. This was deemed crucial for a combined study of the larger political context and household health services utilization. The third was the daunting logistics of project implementation in three large countries, including sampling frame and strategy, and questionnaire development and testing in two languages. Lack of comparable baseline data on service use further complicated the task.

By the same token, this comparative study is unique in the way it combines and integrates both qualitative and quantitative analyses of health care across three countries at various stages in the implementation of their own health sector reforms. It not only sheds light on important issues pertaining to accessibility and equity in the three countries, but also sets a precedent and provides methodological and theoretical guidelines for further comparative work in this area.

The book is divided in four sections. Section I (Chapter 1) sets the scene with a historical narrative, identifies key commonalities and differences between the three systems, raises several socio-political issues of the last decade for contextual analysis, and discusses various conceptual models used in the health care literature before introducing the methodological approach used in this study.

Section II comprises three sub-sections, each including two chapters per country. Thus, chapters 2, 4 and 6 introduce the reader to the context and process of health care reform in Argentina, Brazil and Mexico, respectively. The emphasis is on political analysis of the main stakeholders and various processes followed during implementation, including setbacks and compromises. These chapters reveal how important and influential political traditions, degree of transparency and pluralism, devolution of power, and democratization and governance are in reforming the health care system.

Chapters 3, 5 and 7 take the reader to the heart of the matter. First, the authors describe, both in narration and numbers and figures, the main health and health care issues in each country. Using a similar format, they present a detailed analysis of the relationships between the patients/population, providers and payers in both the pre- and post-reform era. They go on to elucidate changes in the roles and responsibilities of, and ultimately the power shift between, the stake-holders in this tripartite relationship. The emphasis is placed on the main health care functions of regulation, organization, financing, and service delivery.

Section III (Chapter 8) provides a snapshot of the current status of health services utilization in the three countries. The analysis is quantitative and household-based, and is intended to complement the more qualitative and sectoral (macro level) analyses of the previous section. Using a behavioural model as its theoretical background, it presents the findings of a survey with a representative sampling scheme that was carried out in Rosario, Rio de Janeiro, and Mexico City to explore whether system- or patient-related factors play a predominant role in access to and use of health care services. Obviously, such a study cannot differentiate causes from effects, nor can it attribute observed effects to health care reforms because of its cross-sectional nature and lack of pre-reform baseline data. It proved useful, however, in providing a new baseline for future utilization studies. More importantly, perhaps, it revealed — and to a certain extent exposed — some of the inherent inequities in the three health care systems. It did so by showing associations between income, out-of-pocket payment, having a regular source of care, and entitlement, on the one hand, and service use, on the other, at least for the three tracers of hypertension, prenatal care and diarrhea.

Section IV (Chapter 9) provides a thorough discussion and synthesis of the health care reforms in the three countries, draws on lessons from the recent experience, and elaborates possible scenarios for the way forward.

The author notes the crucial roles of the timing of the reform with respect to the economic crisis and the process of democratization; the process of decentralization; and the instruments used to fulfill the key functions of organizing, financing, regulating, planning, and participating in the reform process.

The transformation of the social security system, either by incorporating it into the public health care system or by opening it to competition from private insurers and providers, is at the core of the reform process. On the other hand, the trend toward decentralization appears to be the key issue for the public health care system, although its modalities vary largely from one country to another. The most important change, however, and the one affecting the entire dynamic of the health care sector, is the role of the competitive market in health care insurance and provision.

Possible combinations of the three sub-systems — public, social security and market — suggest three possible scenarios for the future, namely, competitive, dual, or specialized.

Under the competitive scenario, market competition becomes the prevalent modality of organizing the health care system, subordinating or even replacing the public integrated and compulsory models. The dual scenario occurs when both the voluntary and the public system — compulsory or contracted — are strong enough to maintain their own forms in parallel. The specialized scenario is one in which all providing institutions are defined according to the package of health care services they offer to each segment of the population.

Analyzing the feasibility and consequences of the three scenarios yields some lessons from the experience of reform in the three countries and suggests some measures to avoid segmenting the population along socio-economic lines with respect to their degree of access to health care.

Noting that no special mechanism has so far been designed as part of the reform in any of the three countries to promote solidarity across various socio-economic layers of citizenry, the authors believe that the reform processes are likely to deepen inequality in a region already well known for having the worst distribution of wealth in the world.

Health care reform is necessary and important, not only because of the significant improvements it can achieve in terms of access to health care and, subsequently, better health, but also because it is often predictive of the direction that other social and economic reforms will take since it reveals changes in the underlying value system. Depending on the direction it takes, health reform will either reinforce social cohesiveness or decrease it by aggravating existing inequalities — a crucial issue for the three countries in this study. It could also prove a precursor of changes in governance yet to come.

Sonia Fleury
Susana Belmartino
Enis Baris
March 2000

SECTION I.

INTRODUCTION

Chapter 1.
Reforming Health Care in Latin America: Challenges and Options

Sonia Fleury

The Social Protection Model in Latin America

Because of diverse historical processes, each country in Latin America has developed its own system of social protection. Each is the result of a complex web of economic, political, and cultural forces, and each is unique in the way it turns a set of social values shared by the population into a complex network of institutions responsible for financing, organizing, and providing social services delivery, and defining who is entitled to benefits and services.

As Flora and Alber (1981) have pointed out in their comparative study of the development of welfare states in Europe and America, modern western systems of social protection originated in the profound economic, political, and cultural changes that accompanied the processes of industrialization and urbanization. Alterations in authority patterns, changes in community values, weakening family ties, and the emergence of class identity were some of the features that caused responsibility for the provision of individual and family needs to shift from the private to the public sphere. Thus, the role of the state became more interventionist in order to ensure emerging social rights.

Although the development of social protection has a common origin, the institutional form it takes varies according to prevalent values and previously existing institutions. It is also determined by the dynamics of the power struggle between the important classes and social actors — their goals, strategies, alliances, and ability to organize and create social consensus.

Nevertheless, analysts have tried to extrapolate patterns of social protection from specific cases and come up with three ideal types of social protection systems that group similar styles of governmental intervention and organizational arrangement as an outcome of former political choices. These are: the **corporatized system**, the **nationalized system**, and the **segmented system** (Heidenheimer et al. 1983). These indicate, respectively, an insurance-based arrangement, a state-supported system, and a market-based system combined with public assistance.

Some critics feel that such classifications are purely descriptive and cannot properly be called instruments for comparative analysis. Others point out that it is impossible to fit any real system into an ideal type, as an ideal type indicates a prevailing tendency rather than a complex historical dynamic. Although agreeing with this criticism, we cannot deny the utility of identifying the common features in the social-protection development process as a useful tool in the analysis of the present situation of health care systems in Latin America.

Other authors recognize the importance of identifying common patterns of social policies, but call attention to the enormous variation in the arrangement of any specific public policy such as health care. This arrangement is the result of political choices on many different issues, such as: ownership of the services; styles of contracting out; means of regulating professional activities; policy-making structure; techniques of intervention; distribution of health care services; and guarantee of access (Heindenheimer et al. 1983, pp. 52-89). That being said, such a classification is undeniably useful in our analysis of the present situation of health care systems in Latin America.

Latin America has traditionally been ruled in a oligarchic way, combining **patrimonial** mechanisms — the private appropriation of public goods by the elite — with the **populist** exchange of privileges — the co-opting of workers by government — and the social **exclusion** of certain groups of people, mainly the poorest.

Nevertheless, social demands have been incorporated by governmental authorities since the beginning of the 20th century, as part of the process of urbanization and the launch of the industrialization process. Some of the most powerful, complex, and long-standing social security systems are to be found in the region, especially in those countries considered pioneers: Argentina, Brazil, Chile, and Uruguay (Mesa-Lago 1978). There, social security institutions date back to the turn of the century, and have formed one of the most important channels in the relationship between the populist leader and the urban working class.

The government bargained with each labour faction separately, exchanging benefits for political support and thereby deriving its legitimacy. Thus, the social security system was built up on fragmented grounds, with benefits being expanded to the same entitled workers and coverage being enlarged as part of the political game of pressure and bargain, while its financial basis was entirely rooted in taxes and contributions from salaries.

The assimilation of the social demands of urban workers has resulted in different levels of social protection in each country, determined mainly by the degree of homogeneity and organization within the working class (to compare the development of social protection in pioneer countries, see Fleury 1994).

Thus, while social policies and social security systems in Latin America played an important role in the process of state-craft, they did not succeed in spreading civil culture or in extending social coverage. Although the concept of citizenship was based on an egalitarian notion of rights, the concept of social protection in Latin America rested on social and institutional mechanisms of differentiation. Nevertheless, this political give-and-take constituted the first instance in which the demands of the working class were considered in the political arena and incorporated into the government agenda.

From this process emerged the main actors in the social policy arena: the technical bureaucracy; middle-class professionals; unionized workers; and, last but not least, the traditional populist politicians. Social protection was rooted in a political system wherein the state played a key role in the industrialization process by combining industrial protectionism with a controlled political incorporation of urban workers' demands. This apparently strong state interventionism was weakened, however, by the compromises that had to be made with the many conflicting and powerful interests that lent the government legitimacy, but also held it back.

The need to cater to vested interests was responsible, on the one hand, for increased state intervention in social and economic life. On the other hand, it prevented the government from imposing progressive taxes on the productive sector, resulting in chronic fiscal deficit. This populist game, performed by state and society and based on mobilization and concessions, was paradoxically responsible for both the power and the weakness of the state.

As the course of industrialization proceeded, the ever-growing complexity of the political structure, dissatisfaction due to unfulfilled expectations, and the exacerbation of contradictions between co-optation and control made it impossible to fulfill emerging political and social demands. As a result, the expansion and maturation of the social protection system in the region manifested itself as a crisis that could not be resolved within the existing political framework.

With the collapse of populism in the 1960s, social protection institutions suffered an intentional demobilization of popular participation followed by several attempts to concentrate political power in the hands of a bureaucratic–authoritarian central executive.

At that time, the social security institutions controlled by workers in the pioneer countries were about to go bankrupt. The first reform movement carried out by the military dictatorships was to take those institutions out of the hands of the trade unions and put them into the hands of the bureaucracy. This was successfully carried out in Brazil, but failed in Argentina, where the workers were able to keep control of the *obras sociales*, the social security institutions associated with unions.

However, the strengthening of bureaucratic structures was accompanied — to a greater or lesser degree, depending on the country — by a general trend toward de-politicizing social issues, within a context of political suppression and the elimination of representative and organizational channels for expressing social demands.

The rupture with the populist style of relationship between state and society did not change the "corporate pact" of power and control over the political actors by the authoritarian governments. However, bureaucracy was substituted for corporate mechanisms of representation and conflict negotiation, which clearly favored the interests of private entrepreneurs. In the context of social security, this meant private health care providers, whose influence on public policy resulted in a state logic that was predominately private.

In any event, each country was left with a stratified health care system whereby workers in the formal market were entitled to social security benefits while the rest of the population received services provided by the ministry of health. This resulted in significant differences in access to and quality of services.

Regardless of differences in social protection policies from country to country, it is possible to note some common characteristics. These include:

- **duality** — some services are provided by the ministry of social security and others by the ministry of health;
- **fragmented** institutional arrangements that vary in terms of duties and rights according to the bargaining power of the labour group involved;
- **centralization** of the social services system, resulting in **inefficient** service delivery and **poor quality** services;
- **low coverage** by a social security system that provides **uneven coverage** across regions and income classes, and **excludes** workers in the informal sector; and
- **a complex and intricate power structure,** dominated by such powerful stakeholders as politicians, bureaucrats, labour leaders, private providers, international suppliers of health-care inputs, and insurance companies.

Despite these common features, health care in Latin America is provided through a wide range of organizational forms of delivery. An attempt to categorize them can be found in the typology adopted by the Inter-American Development Bank (IDB 1996, p. 309).

Segmented Systems are characterized by the coexistence of the following: social security systems covering workers in the formal sector; a health ministry that carries out some public health interventions and provides health care services for the lower and middle classes; and a very large and diverse private sector that covers the richest, the poorest, and, increasingly, the middle class. Mexico was identified as an example of a segmented system.

Integrated Public Systems are those in which the public system predominates. Financial resources come out of general tax revenues and are allocated to integrated public providers on the basis of installed capacity. Costa Rica was identified as an example of this type of system.

Subcontracting Systems are those in which the government plays an important role in mobilizing resources while provision of services is largely private, usually on a fee-for-service basis applied with various degrees of sophistication. Brazil, where abundant private resources complement public efforts, is the only country in the region to approximate such a system.

Contract-Intensive Systems are characterized by the prominence of social security organizations, for which payroll taxes are the major source of financing. These usually involve a formal separation between finance and service provision, and apply a wide range of service-contracting mechanisms. Argentina was identified as an example of this type of system.

This typology emphasizes the relationship between payers and providers, but also takes into consideration the ownership of health services. As a descriptive tool, it does not indicate the reasons why a health system assumes this configuration, nor its tendencies to reform it. All of them are identified as facing problems in improving the quality of services and achieving efficiency. Nevertheless, it would be misleading to conclude that the different configurations of the health system in the region are coming to the same point of adopting a standardized reform model.

After a Decade of Reforms in Latin America

The structural reforms implemented in the late 1970s and throughout the 1980s saw the emergence of a new style of economic development based on the leading role of private investment and exports, the expansion of private consumption, and a limited role for the state. In most countries of the region, adjusting to the external financial crisis led to regressive income distribution and an acute decline in real wages, further increasing inequality and poverty (O'Donnell and Markovitz 1996).

During the 1980s, the "lost decade," the political and social balance achieved during the postwar era of development quickly broke down. Most of the countries emerged from the adjustment period with greater levels of inequality (the exceptions being Colombia, Costa Rica, and Uruguay) and poverty (except for Chile and Uruguay).

Although economic stagnation and inflation were the main factors responsible for poverty and inequality, adjustment measures taken in response to the fiscal crisis also contributed. The new style of development based on increased productivity and competitiveness deepened existing structural problems such as lack of investment capital (national savings), vulnerability to external shocks, and lack of an income distribution policy to cope with poverty and inequality.

As the region recovered, experiencing economic growth without inflation, purchasing power increased in some countries and the income distribution structure was altered across the region, with varying effects. Only the high-income groups benefited in Mexico, while all income groups benefited in Chile, Colombia, and Uruguay. In Venezuela, the incomes of all groups deteriorated, while in Argentina and Brazil the middle classes and the poor suffered the greatest losses (Altimir 1994). Only in the mid-1990s would the Brazilian stabilization policy succeed in reducing inflation and, consequently, poverty.

According to a report by the Inter-American Development Bank (IDB 1997, p. 17), "after falling continually throughout the 1970s, poverty increased dramatically in Latin America during the 1980s. By the end of the decade, the proportion of the population living in moderate poverty had risen to 35%, and the share of the population in extreme poverty had risen to roughly 17%. During the 1990s the poverty rate has declined very slightly, while the number of poor has increased somewhat...."

Weak recovery in the 1990s was attributed to the insignificant decline in poverty rates, which may also reflect the manner in which the gains from recovery were distributed (IDB 1977, p. 18). Between 1991 and 1995, per-capita income of the top fifth on the income-earning scale grew by 5%, whereas per-capita income of the middle and lower income groups grew by only 3%. The overall conclusion was that the pattern of income distribution has not shifted in this region, which is noted for having the most unfair income distribution in the world.

Concern about the fragility of the region's economic recovery centered on the fact the that growth that has been restored in some countries is heavily dependent on private foreign investment. Many experts have suggested that privatization of the social security funds would be the most promising way to raise private savings (Williamson 1997, p. 51) and reduce reliance on public investment.

While other international agencies attribute these failing efforts to reduce poverty to the weakness of the recovery process, a report by the Economic Commission for Latin America and the Caribbean (ECLAC 1996, p. 44) takes a more pessimistic view. The report attributes the persistence of the same pattern of income distribution to some characteristics of the job market, such as the persistently high rate of unemployment, the limited bargaining power of many wage earners, and the increased income gap between workers with different skill levels.

Economic recovery is of critical importance to the social sector, because the characteristics of the labour market determine access to social benefits, as well as the possibility of joining a private health insurance plan. The formal job market not only determines salary levels, but also the level of resources collected by social security that are destined for the health sector. Thus, the low income earned by a high proportion of public sector workers — in Bolivia, Honduras, and Venezuela, between 30% and 40% of public sector wage earners were below the poverty line in the mid-1990s (ECLAC 1996) — limits the scope for state reform of social security, and especially affects the social sectors, where the lowest salaries in public administration are to be found.

An analysis of the process of change in income distribution and the debate regarding the role played by public policies is revealing. The Chilean case shows that even under sustained economic growth, inequality remains higher now than during the pre-adjustment period, while the examples of Costa Rica and Uruguay show that inequality can decrease as a result of income distribution mechanisms.

The evidence points to the conclusion that there is no economic theory of wealth redistribution, and that the positive results achieved resulted from a set of political policies and increased public expenditure on social services. In other words, Latin America's historic experience illustrates the thesis that, while economic growth is a necessary condition for the struggle against poverty and the reduction of inequities, it cannot by itself improve income distribution. The judicious use of social expenditure is a better way of improving income distribution because it is relative independent from both the level and rate of economic expansion.

The last period of crisis and the implementation of structural economic adjustment measures led to reduced employment and wage levels and increased poverty and inequality throughout the region. Nevertheless, it did not reverse the long-range trend toward improved social conditions. Rather, it reduced the rate of social improvement, particularly in the areas of educational coverage, water and sanitation services, child mortality, and life expectancy at birth. Continued improvement in social conditions must be attributed to the social service networks established in several countries during the period of economic expansion and to socio-demographic characteristics associated with the accelerated rate of urbanization.

Fertility rates have declined rapidly in Latin America since the mid-1970s, reducing population growth and eliminating the threat of overpopulation. The challenge is now to take advantage of this opportunity by improving the quality and coverage of social programs, particularly with respect to young people living in poverty.

In addition to reduced fertility rates, the region has experienced significant economic and social changes in the recent decades, mainly, an intense process of urbanization and the aging of the population. Both phenomena have altered the demand for health care, since urban demands are more visible than the rural demands, and the aging of the population has redrawn the epidemiological profile. To the typical diseases of underdevelopment have been added those prevalent in industrialized societies: cardiovascular disease, chronic illness, accidents, and violence.

In Latin America, the health sector is a powerful economic force, employing about 5% of the economically active population (EAP). Expenditure on health represents on average 5.7% of gross national product (GNP) in the countries of the region (CEPAL 1994). However, public expenditure on health care accounts for only 49% of total health expenditure in the region; private expenditure for 50% and foreign development assistance for the remaining 1% (Govindaraj et al. 1995). In terms of public expenditure on health care, the region does not compare favorably with the world average. Public expenditures on health care in the region is US $121 per person per year, or 2.2% of GNP, less than half of the world average of about US $323 per person per year (World Bank 1993).

While the level of public spending on the social sector increased during the early 1990s in most countries in the region (ECLAC 1996, p. 79), the increases varied greatly between countries. In some countries, expenditures now exceed the levels prevailing in the 1980s. This is the case in Argentina, Chile, Colombia, Costa Rica, Mexico, Panama, Paraguay, and Uruguay. In other countries, expenditures show an upward trend, but have not yet regained early 1980s' levels. Such is the case in Bolivia, Ecuador, and El Salvador. Social expenditures in yet other countries, such as Brazil, Guatemala, Honduras, and Nicaragua, have fluctuated or declined slightly. Moreover, most increased public spending in the region occurred in the areas of education and social security, rather than health.

During the 1980s, reduced public spending was accompanied by an increase in health expenditures on the part of families, enterprises, and nongovernmental organizations (NGOs). The NGO contribution to the region's health financing was significant, totaling US $6 billion between 1980 and 1989. In poorer countries, this contribution was similar to or even exceeded that of national governments.

As a result of reduced public spending, public health services tended to deteriorate, the technological gap between public and private hospital services widened, and the efficiency and effectiveness of publicly managed and provided health care declined. This was accompanied by a growth in services supplied by the private insurance sector, which increased significantly both in affiliation and number of hospital beds. Thus the pattern of supply and consumption moved toward greater involvement of the private sector in health care delivery.

In addition to changing market dynamics, there also occurred in Latin America a great transformation in the social fabric and institutional political framework. Since the 1970s, the old relationship between state and society that had developed during the early years of industrialization — known as the "corporate pact" — showed itself incapable of encompassing the complex and pluralistic network of political actors that emerged as part of the urbanization and industrialization processes. Grassroots social movements and NGOs flourished in the region, becoming a channel for organizing and representing interests that did not fit into the old political order. Even traditional political actors, such as trade unions and entrepreneurs, developed new forms of organization and representation, clearly demonstrating the insufficiency not only the old structure but also the political party and electoral systems. Moreover, the increase in unemployment and changes in the work process have weakened the power of the trade unions in the region and limited their ability to control or implement social policies.

The transition to democracy in many countries of the region in the late 1980s changed the existing pattern of authority into a scene of conflict, where consensus, as well as the institutional framework of democracy, had yet to be built up. In this new context, social and grassroots demands had to be considered in the political arena, some of them becoming part of the government agenda. At the same time, however, economic adjustment measures imposed tremendous cuts in public spending, emphasizing the contradictions between necessities and constraints.

Deepening inequity, the "urbanization of poverty," and the failure of the state to guarantee even minimal economic and social functions (a stable currency, taxation, education, health, and housing), led to unprecedented urban social breakdown, manifesting itself in violence, criminality, lawlessness, and the proliferation of drug trafficking such as can be read about any day in the regional press.

The emerging individualist, or self-centered, system of values acts as a barrier to keeping or developing solidarity, destroying the political and family ties that traditionally provided the poor with social and economic support. Another aspect of individualism, that of consumers' free choice, has had the effect of reducing the power of the bureaucracy to determine the nature of public goods to be offered and the manner of their consumption.

Some Issues in Comparative Analysis

Over the last decade, health care systems in several Latin American countries have undergone a number of organizational changes in line with the worldwide trend toward health sector reform. Such changes were perceived as an answer to the financial crisis of the 1980s, an attempt to make health care institutions more effective and as a way of adapting to the more sweeping process of economic restructuring and the rethinking of the role of the state.

The first question one has to ask about these processes of health care reorganization is whether or not they can rightly be considered as sanitary reform (health reform). Of course the answer will depend on what is meant by the latter.

Sanitary reform encompasses changes at both the institutional and the policy levels, transforming both prevailing values and the authority system that is designed to govern individual actions. These transformations are processed in a sustainable way, no matter whether the strategy has been piecemeal or comprehensive. Reforms are supposed to affect crucial features of health care organization, altering access and utilization, as well as institutional arrangements and political and economic power-sharing among the various actors in the field.

The political process of sanitary reform in Italy and Brazil has inspired a definition that emphasizes the political and the institutional changes (Fleury 1989).

Sanitary reform refers to the process of transforming the laws and the institutional arrangements responsible for protecting the health of citizens, and corresponds to an effective displacement of political power toward lessadvantaged groups. The concrete expression of this change is reflected in the establishment of a universal right to health care and the creation of a national health system headed by the state.

The same emphasis on the political aspect is evident in another concept of sanitary reform (Berlinguer et al. 1988, p. 131), although it also calls attention to the transformations of the health care model and services.

> When we aim to broaden the equality of citizens with respect to health care; to displace the power of the few to the many; to change productive technology and individual behaviour in a healthy way; to recycle the services, the technical interventions, the treatment and prevention of disease; and to drive conscientiously other transformation processes (without which any reform would stay isolated and be defeated), we will clearly face many difficulties and huge resistance. Consensus is the most important weapon to overcome them.

In other words, after the profound changes in the health sector in Europe in the first half of the century, the discussion about sanitary reform acquired a political meaning in terms of:

- rebuilding the power structure by promoting sanitary conscience (health awareness) and organizing a new hegemony;
- altering the legal and institutional health care apparatus, with the state guarantee of universal right and access to a national health system; and
- shifting from a curative to a more preventive orientation, accompanied by more adequate treatment.

The missing point in this case relates to the microeconomic aspects of health care system organization, i.e. the financing and organizing health care units. Recently, this matter has become paramount for reformers, changing the concept of sanitary reform into that of health care reform.

This new wave of health sector reform started in a different context, in the middle of the economic crisis of the 1970s. It was prompted by the increasing cost of health care services and the more complex and expensive demands made on the health system by an aging population. In response to national fiscal crises and to the difficulty of financing health care services, health sector reform is underway or under consideration in countries throughout the world.

Although it is difficult to define precisely, Berman (1995, p. 15) acknowledges that the term "health sector reform" has wide appeal. He defines it as "sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector." He refers to the health sector as all the policies, programs, institutions, and actors that together make up the organized effort to treat and prevent disease.

In a comparative analysis of seven countries that are members of the Organisation for Economic Co-operation and Development (OECD), Hurst (1991, p. 14) tries to find similarities in terms of some set of objectives as expressed in their health policies. They areas follows:

- individuals should have adequate and equal access to health care;
- payment should be linked to an individual's ability to pay;
- health expenditure should consume an appropriate fraction of GDP (macroeconomic efficiency);
- the mix of services provided should maximize health outcome and consumer satisfaction for the share of GDP expended (microeconomic efficiency);
- consumers should be free to choose arrangements from both the public sector and the private sector; and
- doctors and other providers should be given the maximum freedom compatible with the attainment of these objectives (appropriate autonomy).

The concept of reform that grew out of the attempt to overcome the crisis in the welfare state focused on the need to increase the efficiency and reduce the cost of health services. It also proposed changes in the role of the state and private providers, as well as a shift in the status of the user. This concept of reform sees the state as having a minimum responsibility while assuring the providers their autonomy and dealing with the users as consumers with freedom of choice. Equity of access and protecting patients against financially debilitating payments for health care are also on the agenda, mostly in the developed countries although not in the United States. The discourse of empowerment that accompanied the first reform movement has been replaced by one that emphasizes rationality and competition.

According to Chernichovsky (1995), the systematic functions involved in the new generation of reforms are the financing of care, the organization and management of the consumption of publicly funded care, and the provision of care. Reforms in line with this paradigm attempt to combine the advantages of universality, efficiency and consumer satisfaction by offering universal access to a basic package of care through decentralized, mainly private, systems of delivery. To achieve this goal, the two functions of financing and provision must be separated because the first is guided by a public principle whereas the second is based on competition.

International agencies and experts from the region took part in a special meeting in 1995, In order to build a regional agenda for health sector reform in Latin America (Health Sector Reform Seminar 1995). Participants in the seminar defined health sector reform as, "a process aimed at introducing substantive changes into the relationships between and roles performed by the different agencies involved in the health sector, with a view to increasing equity of benefits, efficiency in management, and effectiveness in satisfying the health needs of the population."

The objectives of health sector reform for the region were identified as follows:

- to improve the health and living conditions of all the inhabitants of the Americas;
- to become, along with justice, well being, and equity, one of the pillars of development in the region;
- to reduce health status inequalities, improve access to good quality health services, and foster shared responsibility between institutions, individuals, and communities;
- to modernize and decentralize the organization and operation of public institutions providing health services;
- to balance the public and private health sectors in order to achieve a synergy in their efforts; and
- To ensure that sufficient financial resources are available to the sector at a sustainable level to accomplish the aforementioned objectives.

The emphasis is on regional problems and strategies, such as promoting equality of access; improving the quality of health services; modernizing the state and decentralizing the provision of services; and gathering resources to operate and finance the health care system.

Nonetheless, the concept of health sector reform proposed for Latin America neglects some important aspects of the health sector, such as the development of science and technology, human resources training, and the ever-increasing proliferation of curative treatments.

In this research project, we have avoided choosing an existing concept of health sector reform, because we felt that it would lead to an analytical bias in favour of one concept or another. We have also tried to avoid considering health sector reform as a simple rearrangement of organizational variables such as financing, provision, and coverage. Rather, we have chosen to conceptualize health sector reform in terms of the following dichotomies:

- universal versus segmented policies;

- mechanisms of solidarity versus equity between contributions and benefits;
- integrated systems versus fragmented systems; and
- decision-making processes based on participation versus decision-making processes based on competition.

Actual health sector reforms can be expected to fall somewhere along the continuum between the two extremes, permitting many different arrangements. Also, a tendency in one direction or another will be restrained by the existing institutional and political organization, tending to add to the diversity and complexity of the reforms.

We agree with the conclusion of the Health Sector Reform Seminar (1995, p. 11) about the diversity of processes in the region.

The objectives, scope, and substance of reform, as well as the strategies and mechanisms adopted for their implementation, vary markedly. Some reforms are comprehensive, simultaneously encompassing the organization, the financing and the resources of the sector as a whole. Other reforms are intended to implement only partial changes among some of the institutions or roles of the health sector. In some cases, reform involves the promotion of greater private sector participation in health, whereas, in others making decentralized and democratic government more responsible is what has been attempted.

One way to avoid the problem of diversity when comparing the reforms is to analyze the purposeful change made by governmental authorities, and expressed in legal instruments. But this may be misleading. Kroneman and Zee (1997) call attention to the troublesome task of investigating health policy reforms at the national level, because of the difficulty of establishing when a certain policy change took effect and of determining the content of the reform. The difficulties are due to regional variations in a decentralized system, as well as to the fact that reforms are a gradual rather than a straightforward process. Moreover, deliberate vagueness in national policies is used by reformers as a means of avoiding confrontation with health care providers and other actors, and of creating broad support for the reform.

Nevertheless, a framework can be constructed that avoids these pitfalls by focusing on the accomplishments and problems associated with various national experiences currently underway. For example, in examining the purpose, content and scope of the sanitary reform processes in Argentina, Brazil, and Mexico, it is possible to discern a common trend toward modifying the relationships between public and private agents and between different levels of government.

In our comparative framework, we decided to concentrate on the changing aspects of the health care system, thereby focusing on the main point of consensus in different concepts and processes of sanitary reform. Both those processes that emphasize the political aspect of reform and those that emphasize its managerial content have in common the fact that all the intended changes should appear in the organizational structure of the health care system.

Although the decision to concentrate the comparative study on the health care system may avoid problems related to the definition of reform, other comparative issues persist because health systems comprise many complex interactions permitting innumerable variations in policy and in delivery and control mechanisms. This complexity leads many authors to doubt the possibility of accomplishing comparative analysis at all.

For Ellencweig (1992, p. 16), "… the only axiomatic statement that can unify all health systems and their subdivisions would be that they differ from each other. Those differences are not due to chance alone, rather they are rooted in the organization of societies." Similarly, Light (1997, p. 109) states that "in some ways, health-care systems are inherently not comparable."

Nevertheless, many studies have attempted to compare national health care systems, mostly using a health service model. The health service model develops criteria to group national health systems on the basis of a cross-sectional assessment of each of their components. (Ellencweig 1992, p. 25). One weakness of this model is its implicit effort to reduce the explanation of a multifaceted health care system to one or two variables. Its other weakness is that it disregards trends over time.

Roemer (1977) is the most outstanding advocate of the health services approach. He distinguishes the evolution of health systems by identifying four major attributes: historical perspective, political process, socioeconomic environment, and cultural characteristics. His comparative study (cited by Light 1997, p. 109) presents a dynamic model of common elements based on five factors: resources, economic support, organization, management, and delivery of services.

Traditional taxonomy of national health systems was based on ownership, including accountability for financing and provision. This classification could accommodate many different variables, from societal values to market or institutional arrangements involved in a national mandatory insurance scheme. More recently, with the increased complexity of health systems, many different relationships have developed between the government, mandatory and voluntary insurance schemes, and private providers. Thus classification of health systems by ownership is no longer considered useful. Instead, more recent typology is based on the functions performed by each component of the system: financing, regulation, organization, and provision (Lodoño and Frenk, 1997).

The health care system is analyzed in terms of its capacity to integrate either populations or institutions. With respect to populations, integration means the extent to which different groups are allowed access to every institution in the health system. Regarding institutions, integration refers to the arrangements for carrying out the functions. Upon this framework, Lodoño and Frenk (1995) created the following typology of health systems models in Latin America:

- the **unified public model**, featuring vertical integration of institutional functions and horizontal integration of populations;
- the **segmented model**, featuring vertical integration of institutional functions and segregation of populations;
- the **fragmented model**, featuring separation of institutional functions and horizontal integration of populations; and
- the **atomized private model**, featuring separation of institutional functions and segregation of populations.

This new way of classifying the components by function is based on two premises: the necessity of separating the financing and provision functions, and the existence of more than one type of public-private mix. The typology is used as a way to reach a proposal for a new arrangement for health care systems in Latin America called "structured pluralism."

Gonzalez-Block (1997, p. 201) identifies this approach to comparative analysis as the use of an "ideal type" model, abstracted from the institutional arrangements and processes found in existing health care systems in industrialized countries so as to maximize certain desirable attributes. He also points out some problems in the use of an ideal type, for example, the possibility of oversimplifying existing institutions and actors, as well as the normative aspects implicit in it. "Structured pluralism" is put forward as the best arrangement to achieve efficiency, responsiveness, accountability, and solidarity through an appropriate mix of public and private financing, delivery, and regulation. However, this arrangement tends to conceal the political and ideological aspects by treating any possible arrangement of relations and variables as a matter of technical expertise.

In addition to the health services approach, Ellencweig (1992, p. 22) identified two other kinds of taxonomy used in the comparative analysis of health systems: the health policy approach and the epidemiological model. The politico-economic approach is a policy-oriented model that has been adjusted to distinguish between national health systems based on the assumption that they really do manifest clear-cut ideologies (Ellencweig 1992, p. 29). As distinct from the static health services approach, the politico-economic approach encompasses historical, political and economic processes, although it fails to provide concrete tools for comparing the elements of health care systems.

The epidemiological approach applied to comparative health system analysis works with multiple dimensions, such as the social (covering political, socio-cultural, economic, and demographic elements), the institutional, and the individual. This multilevel analysis assigns causal effects to a variety of factors and is used to study the interrelationships between several effects and their causes (Ellencweig 1992, p. 35).

Despite the importance of multilevel analysis and the historical perspective, it would be difficult to establish direct causal links between different political and economic orientations and the institutional arrangements of health care systems. The same holds true for linkages between the institutional and the individual levels.

To cope with the difficulties involved in implementing a cross-national multidimensional comparative analysis, Ellencweig (1992, p. 36) proposed the construction of a modular approach.

The modular model is made up of a number of separate modules which can be grouped together as needed.... Comprehensive cross-comparisons of systems might be desirable but are often beyond reach. The study of longitudinal trends is similarly limited. However, we can still make several comparisons that can be valuable on a narrower perspective, even when only a few modules are available for comparison. The big advantage of the modular approach is that it can be used for solving problems of various sizes. From the many modules making up the system, appropriate modules may be chosen for each problem to be solved.

The weakness of this approach is due to the inherent difficulty of linking the results found in several modules. Even so, the approach seems useful in comparative analysis, in that it permits different levels of comparison, from the suggestion of analogical association to the establishment of causal links based on evidence.

Methodological Options

For the reasons described earlier, we have adopted a modular approach to study the ongoing health care reform processes in Argentina, Brazil, and Mexico in a comparative manner.

Chapters 2, 4, and 6 of Section II consist of a politico-economic analysis of the macroeconomic and social transformations in the region over the last 20 years and describe the way that these may have affected the institutional arrangement of the health care system.

The theoretical model underlying the design of the study assumes that each society, at different times in its development, assigns priority to certain organizational forms and regulatory mechanisms of the health care system, associating these instruments with values such as equity, freedom of choice, and efficiency.

The intention is not to establish causal links between macro socioeconomic process and health care system reform. The presumption is rather that health care systems are driven by values, institutional dynamics, political choices, technical interventions, popular demand, and pressure from actors with different degrees of control over important resources in the health care arena.

The aim of Chapters 3, 5, and 7 is to analyze the political, institutional, and health environment into which health care reforms were introduced in each of the three countries, using a politico-economic approach. To maintain a historical perspective, we reconstructed the background influences and primary factors that could have affected the launch and political meaning of health care reform processes.

Chapters 3, 5, and 7 also describe the legislative and administrative tools used to effect health care reform, as well as the strategy adopted to implement it. The implementation process itself is the result of powerful dynamics among different actors in the health care arena, representing several vested interests. Usually, the result is a complex process of give and take, sometimes yielding results that differ profoundly from what was originally intended.

The evaluation of the overall process is intended to point out the stresses and contradictions, as well as the differences between rhetoric and reality, in each country. The discussion of dissimilar realities is limited to a careful description of the reform processes founded on a common analytical framework, although the method could allow the identification of similarities and differences in terms of general trends. To overcome the criticism related to the use of a highly conceptual model and the lack of tools for comparing elements making up the health system, we decided to complement these studies with a second comparative module.

Chapters 3, 5, and 7 of our analytical model take a health care systems approach and apply it in each country. To avoid the tendency to adopt a simplistic model based on a one-dimensional typology, we decided to build a comparative framework of health systems, encompassing the main dimensions that are likely to be affected by existing reform processes. In each dimension, we grouped important variables, aiming to characterize the methods of financing, regulation, organization, and provision.

The model adopted in this component of the study includes the reconstruction of such interactions in a historical perspective, focusing on changes in the following:

- the regulatory capacity of the main actors within the health sector;
- prevalent organizational forms characterizing services with regard to ownership, professional profile, and resource allocation;
- sources of financing, risk-sharing options, financing methods, and monetary flows; and
- conditions of provision of services to different population groups, and the results in terms of equity, accessibility, and efficiency.

The static characteristic of the health system approach could be minimized by illustrating the health care system at different points in its development along the reform process. Using the same framework (financing, regulation, organization, and provision), we describe the health care system arrangements in the 1970s and the 1990s, to achieve a comparative picture of each system's organizational and institutional transformation.

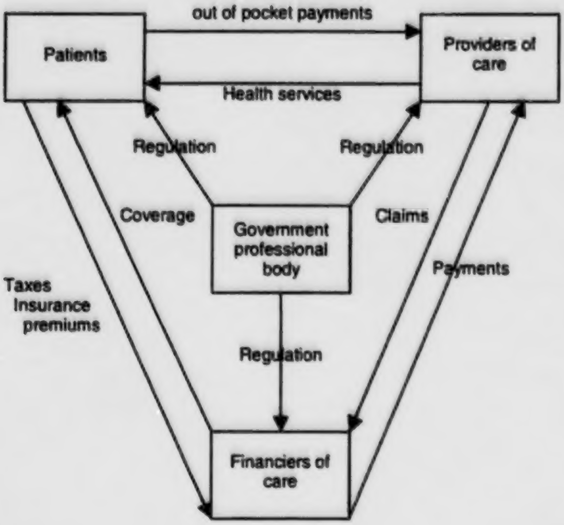
To understand the dynamics of the reform process through the relationships and interactions between the main actors, we adopted the model proposed for OECD study of comparative sanitary reforms (Hurst 1991). It identifies five principal actors in health care systems:

- consumers-patients;
- first-level providers;
- second-level providers;
- insurers or third-parties; and
- government as regulator of the system.

One can analyze the transformations that have occurred in recent years in the health sector through the changes in the relations between the main actors, as described in the schema shown in Figure 1, which is well known in the literature on health care reform.

Using the interactive approach, we will analyze the links between: financiers and providers of health care; the population and financing entities; and

Figure 1. Internal relations in health care systems.


out of pocket payments
Patients
Providers of care
Health services
Regulation
Regulation
Coverage
Government professional body
Claims
Payments
Taxes Insurance premiums
Regulation
Financiers of care

patients and providers. Finally, we will refer to the instances and regulating methods operating in the systems analyzed.

In a comparative analysis of several countries implemented by the Organisation for Economic Co-operation and Development, seven basic arrangements were identified (OECD 1992, p. 19-27), according to the flow of patients, the flow of money, and the relationships of authority:

- the **voluntary, out-of-pocket model** where there is no insurance and health care is based on direct, out-of-pocket, fee-for-service transactions between consumers and primary- or secondary-level providers;
- the **voluntary reimbursement model** based on the full or partial reimbursement of patients for medical care bills within a private voluntary insurance scheme;
- the **public reimbursement model** based on the same reimbursement principles as the above, but within a public compulsory insurance scheme;
- the **voluntary contract model** whereby independent providers supply services to the insured under private contractual agreements, mostly free of charge;
- the **public contract model** based on a compulsory public insurance where independent providers supply services to the insured under capitation or fee-for-service payments;
- the **public integrated model** based on a public compulsory insurance as above, but delivered by non-independent providers, usually paid through salaries and prospective budgets; and

- the **voluntary integrated model** based on private voluntary insurance, delivered by salaried providers with prospective budgets.

This characterization of models of interaction not only allows us to compare the basic design of various systems, but also the dynamics of their transformation with regard to some of the most important dimensions of health policy. It can be expected that whenever the health care system is segmented rather than integrated, as in Latin America, parallel policies, institutions, and systems for different population groups will result.

The possibilities for comparison between the three countries are restricted at the outset by the unique configuration of the health care system in each country. Nevertheless, similar trends may be evident even if they occur in different organizational settings. Our hypothesis is that the reshaping of health care systems over the last 20 years has broadening freedom of choice between providers, rendered coordination more difficult, and aggravated existing inequities with respect to the accessibility, utilization, and quality of services in the health care system.

Another important criticism of the use of the health care system approach is that its national focus limits its ability to discern variations imposed by ongoing tendencies toward decentralization and privatization.

The third module is a quantitative study of the utilization of health care systems in three cities: Rosario, Argentina; Rio de Janeiro, Brazil; and Mexico City, Mexico (Chapter 8). Questions may be raised regarding the ability to draw conclusions about the national health system based on a study of one city. Aside from practical considerations, our justification for adopting this approach is that the selected cities exhibit the main features of the national health care systems of which they are a part.

Service use, measured at the individual level, was the key outcome. The quantitative approach used in this module allowed us to look for causal links between the configuration of the health care system and the utilization of services. However, being cross-sectional in nature, such an approach does not lend itself to attributing causal relationships between variations in service use and reform measures. For this study, we used a theoretical model akin to Andersen and Newman's behavioral model on health care utilization (Andersen and Newman 1973) and applied it to service use specific to four tracer conditions. A survey was designed to reveal the causal relations between three sets of components of the Andersen and Newman model:

- The **predisposing** component comprises those factors that existed before the onset of illness. a set of demographic, socio-cultural, cognitive, and attitudinal variables that are postulated as personal factors that identify the potential risk group but cannot be modified through health policies.

- The **enabling** component consists of the organizational and financial factors that affect the individual's ability to access a given service.
- The **need** component expresses the individual's perceived need for care.

The predicted relations between these components are as follows:

- **Predisposing variables** may influence health services utilization through their effect on the enabling component and on the need variable, as well as directly.
- **Enabling variables** influence utilization directly and also through the need variable.
- **The need variable** influences utilization directly.

Path analysis allows us to divide the correlation observed between variables into direct and indirect effects.

The hypothesis for our quantitative study is that the health care system will be more or less equitable depending on the weight of the enabling component in the utilization of health care services by patients. The higher the weight of the enabling component, the less the utilization of services is based on perceived need or predisposing factors, and hence the more inequitable the system.

The tracer conditions were selected taking into account the epidemiological characteristics of the population under study; the biological characteristics of the tracer condition, determining the form and frequency of utilization of health care resources; the type of attention required; and the discretionary or non-discretionary use of services. The selected tracers were diarrhea, hypertension, pregnancy, and delivery.

The survey used a two-stage, self-weighted, and probabilistic household sample to identify all individuals having at least one tracer condition. The task of designing the research and making the sample comparable came with recurrent methodological challenges. The challenges arose in each stage of the inquiry, including the definition of the variables, the sample design, and the collection, synthesis, and analysis of the data.

The decision to work with a modular design was based on our concern to consider health care reform in as deep and extensive a way possible. Although we are aware of the difficulties in combining quantitative and qualitative approaches, we prefer to take a broad rather than a narrow perspective on reform. The complexity of the object should be no excuse for a partial approach to the reality.

SECTION II.

ANALYSIS OF HEALTH CARE POLICIES

Chapter 2.
The Context and Process of Health Care Reform in Argentina

Susana Belmartino

Introduction

This chapter will present a historical perspective on the reform of health services in Argentina. First, it will analyze the macro socioeconomic and political context within which the reform took place. Next, it will trace the legislative and institutional development of the reform. Finally, it will present a political analysis of the particular conditions in the health sector that limit the ability of the state to regulate it.

The reform of the health services system (HSS) in Argentina came about as a consequence of the grave economic crisis of the 1980s. At that time, the role of the state in the economy and social welfare was shaped by the need to cope with the explosive growth in demand that arose from the recovery of democratic institutions. As well, over the past 15 years, Argentine society had undergone profound changes to its economic structure and political system, which generated particular problems with respect to social integration.

The impact of the crisis on Argentine society was similar to that which occurred elsewhere in Latin America, being characterized by a marked drop in production levels, accelerated inflation, a drastic reduction in economic activity, and high unemployment. External indebtedness imposed the need to generate ever larger trade surpluses, while maintaining a balanced budget to ensure monetary stability. Other effects of the crisis included increasing instances of social exclusion, the pauperization of the middle classes, and an alarming spread of extreme poverty.

The most apt word to describe Argentine policies in the 1980s is "adjustment": adjustment of the productive apparatus to world market conditions; adjustment of the financial system to production levels; and adjustment of state spending to available resources. The unavoidable modernization of the state reinforced the socially exclusive features of the economic policies adopted by emphasizing cutbacks in personnel and spending without directing available resources toward social programs.

Beginning in 1991, the success of the Convertibility Plan[1] stimulated the recovery of internal and external investment, making greater flexibility in spending possible. Important changes had taken place in the structure of the productive apparatus, as well as in social and institutional forms of organization.

The most salient features of the new economy were as follows: the consolidation of new economic and financial groups representing local capital; the development of specialized natural resource-intensive industries; and the redefinition of the terms of entry into international trade, particularly in matters concerning the profile of exports. In addition there have been important changes in the world market, in trade union activity, and in the production of certain public services, as a result of new strategies of deregulation, privatization, and the opening up of the economy.

No less important were the changes in the political system, which have not been confined to the recovery of democracy. President Menem's administration has continued the "presidential" tradition whereby the executive takes the leading role and parliament shows little initiative. The Menem administration benefited from much better conditions for untroubled government than its predecessors and was able to take advantage of a favorable international climate and obtain support for its transformation policies from large national and international investors. Other factors that worked in the government's favour and helped get the reforms underway were as follows: the support of the supreme court of justice, which enabled the President to legislate by means of Decretos de Necesidad y Urgencia (emergency decree); the inability of the opposition to appear as a feasible alternative; the weakening of the trade unions; and, in particular, the fragmentation of the labour movement.

These policies had a number of positive results in terms of macroeconomic indicators: inflation control; high investment rates; a large growth in the gross domestic product (GDP) between 1991 and 1994; an increase in productivity in specific sectors; a significant increase in the export of goods and services; and recovered equilibrium in terms of balance of trade and balance of payments. Negative aspects included a contraction of the labour market, with accompanying unemployment and underemployment; difficulties in achieving fiscal balances in 1995, 1996, and 1997; and excessive dependence on international financial flows due to an underdeveloped local capital market and insufficient domestic savings.

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[1] The Convertibility Plan decreed that the issuing of local currency would be limited to the amount of the reserve in United States dollars (USD) in the Banco Central de la República Argentina (central bank). The rate was fixed such that 1 Argentine peso = 1 USD. The aim of the plan was to boost confidence in the stability of the Argentine currency.

In the area of social policies in general, and those relating to the health sector in particular, there were important differences between the policies pursued by the Alfonsin administration (1983–89) and that of President Menem (1989 to the present). In the former case, rationalization and cost-cutting strategies were oriented according to guidelines advocating strong state intervention, maintaining the bases of solidarity, a tendency toward universality, and the participation of business, trade unions, and professional associations. By contrast, the present administration has emphasized deregulation, privatization, and contracting freedom in matters related to the organization and financing of health care, especially since implementation of the 1991 Convertibility Plan. At the same time, It has put into effect plans to focus on and support social demands in specific areas on the basis of agreements reached with the World Bank.

Background Influences

In Argentina, the health services system (HSS) was historically made up of three relatively independent subsystems: public, private, and social security. From the 1960s onward, each of these subsystem and the relationships between them underwent considerable changes, resulting in the HSS that is now the subject of reform.

The HSS that existed between the 1960s and the 1990s was characterized first and foremost by the decline of the public subsystem — the one responsible for providing health care to the poor — both in terms of financial and material resources and in technical and managerial efficiency. This decline was compensated for by the growth of the social security sector and by an expansion of services on the part of the private sector.

The social security sector was composed until recently of a large number (about 370) of institutions called *obras sociales* that acted as health insurance funds for workers and their dependents. The *obras sociales* originated and grew under the trade unions' control. The system was institutionalized in 1970 with the passing of Law 18.610. This law made it mandatory for employers and employees to contribute to the *obra social* administered by their trade union. The *obras sociales* provided health care to their beneficiaries in two ways: through their own health services and by contracting facilities from the private sector. This form of organization became the basis of the HSS, which gradually grew more varied and fragmented as each trade union developed its own health care service, or subcontracted it from the private sector, with little regulation or coordination by the state. In less than a decade, a considerable expansion of private facilities occurred, measured in terms of physicians, hospitals, and technology.

In the absence of state regulation, the HSS fell under the control of two large groups of associations: the *obras sociales*, on the demand side, politically represented by the Confederación General del Trabajo (CGT, general labour confederation); and the medical federations and private hospital owners' organizations, on the supply side. Since the 1960s, private health care institutions have been grouped into large federations at the national level comprising physicians, biochemists, pharmacists, dentists, and providers of services for inpatient care. Until very recently, these large tertiary federations, representing provincial federations and local associations, have maintained control of the power to contract with the *obras sociales*.

The Instituto Nacional de *Obras sociales* (INOS, national institute of *Obras sociales*,) was the state agency responsible for managing the system. Its main function, according to Law 18.610, was to regulate the operation of the *obras sociales*, so as to reduce the large differences in financial capacity between them and to guarantee their beneficiaries access to a basic set of health services. The INOS was responsible for monitoring contracts between financing institutions and the large physicians' federations. The regulatory capacity of the INOS proved insufficient to reduce the inequalities between *obras sociales*, however, and they continued to vary in terms of number of beneficiaries, institutional regime, consumption profile, cost structure, and service model. The result was a mosaic of arrangements, differing from region to region and union to union.

No sooner was the system introduced in 1970, than attempts were made to reorganize it. The proposed reforms attempted, on the one hand, to assure better use of resources and a more equitable distribution of benefits. On the other hand, they sought to take control of the *obras sociales* away from the trade unions, which had gradually become a source of political and economic power, in many cases, to the detriment of their specific function.

Attempts to reorganize the system in 1973, 1978, and 1985 failed due to concerted opposition on the part of the CGT. With the passing of Laws 23.660 and 23.661 in 1989, modifications were made in the norms regulating the system, but no changes were made to the fundamental parameters governing its organization. By this time, financial deficits were seriously hampering the operation of the *obras sociales*, prompting them to raise their members' contributions on several occasions. Law 23.661, the purpose of which was to lay the legislative basis for the development of a national health insurance scheme, put the system under control of a new agency dependent on the Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action). The Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration), as it was called, proved as incapable of imposing order as its predecessor, INOS. The new law also modified the system's nomenclature, now referring to the heterogeneous group of *obras sociales* as "health insurance agents." This initiative was based on the expectation that under the control of ANSSAL, the system would gradually expand through the voluntary incorporation of independent provincial *obras sociales*, as well as some mutual aid societies.

To complete this summary of the situation of the HSS at the time the reform began, it is necessary to take a look at private health insurance institutions, called Empresas de Medicina Pre-paga. These institutions originated in the late 1960s, but were of limited significance up until the beginning of the 1980s. From then on they grew in importance and became a supplement to, or a substitute for, the *obras sociales* as far as the higher-income segments of the population were concerned.

The private health insurance institutions were as heterogeneous as the *obras sociales*. Some were organized by physicians' associations and large private hospitals with a view to increasing the number of options for financing their services. Others were companies that functioned exclusively as financing agencies, subcontracting private services for their clients' coverage. To complicate matters, some of these companies acquired facilities of their own, with a view to becoming more competitive.

The Reform Process

Formulation of reform policy

The hyperinflationary period of 1989–90 paved the way for reforms that went well beyond the framework of the health services system (HSS). The main instruments for transforming the Argentine socioeconomic system were the State Reform Law and the Economic Emergency Law, passed in 1989 as part of the agreement that resulted in Raul Alfonsín handing over power to Carlos Menem before the scheduled date.

The State Reform Law declared practically all state enterprises to be subject to privatization and modified the regime governing public services. The Economic Emergency Law firmly tackled the issue of reducing public spending.

It suspended all subsidies and grants affecting the national treasury, promotion regimes for mining and industry, and all regulations restricting foreign investment. At the same time, it authorized the executive to divert to other uses funds having a specific purpose; to revise contracts with public employees, to modify the labour indemnity system; and to set up a penal regime for noncompliance with tax obligations. The reform strategies adopted a course decidedly favoring deregulation of the economy.

With respect to health, in 1991, the Ministerio de Economía de la Nación (ministry of the economy) launched a strategy aimed at centralizing social security contributions, with a view to facilitating control of these resources by state officials. To this end, the government established the Sistema Unico de Seguridad Social (SUSS, unified social security system), under Article 85 of the Economic Deregulation Decree (2.284/91). SUSS was dependent upon the Ministerio de Trabajo y Seguridad Social de la Nación (MTSS, ministry of labour and social security), and established the Contribución Unica de Seguridad Social (CUSS, unified social security contribution) to combine social security and health care contributions. The law gave SUSS the power to collect, administer, and supervise the distribution of all payroll deductions through the Fondo Solidario de Redistribución (FSR, solidarity redistribution fund), created under Decree 2.741/91. The percentage of funds destined for financing health care services was then apportioned to the respective *obras sociales*. This measure had the effect of making the system of resource collection and allocation more transparent, clearly establishing the number of beneficiaries, and facilitating the control of evasion.

In 1993, further advances were made on the reform policies in an attempt to solve two problems associated with the *obras sociales*. The first was related to the obligation imposed on workers to pay their health security contributions to the *obra social* associated with their particular trade union. In the view of the proponents of reform, this mechanism ensured a "captive" clientele incapable of raising the quantity and quality of services supplied or organizing a more efficient administration of resources. It was believed that generating a certain degree of competition between the *obras sociales* might stimulate a greater degree of efficiency in their management and lead to the concentration of many small institutions into a few large ones capable of generating an adequate risk pool. In this way, it was hoped to reduce the great differences between institutions as to numbers of beneficiaries and availability of resources, which are frequently alleged to be the source of inequality in terms of benefits.

The second critical factor was the growing proportion of beneficiaries of *obras sociales* who were compelled to seek health care from the public subsystem. This phenomenon related to financial difficulties that compelled the *obras sociales* to resort to extra payments (co-payments) for additional service coverage. At the same time, professionals dissatisfied with low remuneration from the *obras sociales* began to charge their patients an additional fee at the time of service delivery. This extra fee was too much for some low-income beneficiaries, who were forced to resort to the free public services. Surveys of several general public hospitals revealed that 30–50% of their patients actually had insurance, even though the hospitals recovered only a negligible fraction of their costs from insurers. Of *obras sociales* members who were hospitalized in 1994, 5% reported that they relied on public health services, frequently without cost recovery.

The adoption of new mechanisms that would allow hospitals and health centres to receive payment for their services has by and large been accepted, as it is believed that this will help alleviate their deficits and increase their cash flows.

Political perspectives on reform

We will now analyze the two rival visions of reform upon which the debate centres. These are the reform program proposed by the World Bank and accepted by the government, and the solution proposed by the Confederación General del Trabajo (CGT, general labour confederation).

Proposal backed by the World Bank

The Programa de Apoyo a la Reforma del Sistema de *Obras sociales* (PARSOS, program in support of reform of the *Obras sociales* system), is backed by the World Bank and does not differ in concept from the strategy adopted by the government. Rather, it seeks to promote certain mechanisms. These have been listed in a recent publication by the Ministerio de Trabajo y Seguridad Social de la Nación (MTSS, ministry of labour and social security) as follows:

- introduce competition into the financial market, avoid risk selection;
- reassign resources from the Fondo Solidario de Redistribución (FSR, solidarity redistribution fund) strictly on the basis of income collected and risks per beneficiary;
- develop an effective regulatory framework;
- develop insurance institutions that are competitive, transparent, and accountable, to protect consumers' rights; and

- provide financial and technical assistance to the *obras sociales* and the Programa de Atención Médica Integral (PAMI, comprehensive health care program)[2], to enable them to increase their efficiency, balance their accounts, and comply with new norms and regulations.

The project also contemplates the preparation of lists of *obras sociales* beneficiaries, based on information that can be obtained from the Dirección General Impositiva (DGI, general administration of taxes). The specific purpose of this is to determine the number and risk factors of beneficiaries and their dependents. This information is essential for allocating subsidies, for maintaining transparency in contracts with health care managers, and for collecting fees for services supplied by public hospitals.

A proposal was also put forward to define a Programa Médico Obligatorio (PMO, basic services package), able to guarantee minimum coverage within budgetary restrictions.

The Fondo de Reconversión de *Obras sociales* (FROS, *Obras sociales* reconversion fund), was created to facilitate reform of the *obras sociales'* management. This would include helping them balance their budgets, restructure their debts, rationalize personnel, improve their managerial and information capability, and sell off idle assets. Participation in the program is voluntary, but to date 73 *obras sociales* representing 5 million beneficiaries have joined the program.

Counter-Proposal by the Confederación General del Trabajo

This proposal aims to rationalize the *obras sociales* under the autonomous coordination of the Confederación General del Trabajo (CGT, general labour confederation), while retaining the existing institutional structure and without generating competition between institutions or giving in to World Bank directives. The first point of the proposal deals with the definition of a Programa Médico Obligatorio (PMO, basic services package), along the lines that were later adopted by Decree 492. Once the PMO is defined, the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration) will subsidize organizations unable to finance its application because of lack of resources.

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[2] PAMI is the most important *obra social* in terms of the number of beneficiaries, and is one of the leaders in availability of resources per capita. It has suffered from meddling by different governments and has fallen prey to inefficiency, political patronage, and corruption. It is currently in a situation of serious financial deficit.

Should an *obra social* be unable to comply with the PMO due to misappropriation of funds, excessive management costs, inefficiency, noncompliance with quality standards, service irregularity, or any other cause detrimental to its function, ANSSAL has the power to merge it with another *obra social*.

The Fondo Solidario de Redistribución (FSR, solidarity redistribution fund), would not only compensate organizations receiving insufficient resources, but would also aid in such processes as staff restructuring, negotiating with suppliers, upgrading equipment and facilities, and canceling current liabilities through loans.

An important difference between the CGT project and the PARSOS project supported by the World Bank concerns distribution of subsidies by the FSR. In the CGT's proposal, the subsidy bears no relation to individual contributions by entitled beneficiaries, but is related instead to the average income per beneficiary of the *obra social*.

Implementation

Dispositions regarding social security institutions and their relations with service suppliers

The succession of government dispositions intended to give the reform a legislative framework illustrates to some degree the political conflict we have touched upon. Efforts to deregulate the *obras sociales* came one after the other without really being put into effect, the result of clashes that go beyond the bounds of the health sector. The following paragraphs contain a synthesis of the health reform legislation that has been approved.

Decree 9/93 (7 January 1993)

Decree 9 of 1993 sets out the guidelines for reform. It establishes, within certain limits, freedom of choice for affiliates to *obras sociales*. Named beneficiaries are entitled to choose between the system's component institutions and to change their affiliation once a year. The decree also establishes that the Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) will determine which basic services each *obra social* must deliver, and that the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration), will cover the difference between contributions received and the actual cost of the services delivered.

The decree also undertakes to reform relations between *obras sociales* and providers of services through the following dispositions:

- The *obras sociales* are given freedom to contract with providers of services, without restriction as to scheduled fees, thus introducing price competition between health care suppliers.
- The *obras sociales* are forbidden to contract with institutions responsible for issuing professional licenses or limiting the right of their members to contract directly. This disposition excludes from the market those agents that have traditionally controlled the offer under oligopolistic conditions, that is, the professional associations.
- Contracts signed between *obras sociales* and providers shall contain criteria for categorizing and accrediting such providers, with the purpose of optimizing quality in health care.
- The *obras sociales* shall pay public hospitals for the services provided to their beneficiaries. This disposition is completed by Decree 578/93 regulating the *hospitales de autogestión* (self-managed hospitals). Self-managed hospitals are public hospitals that are empowered to manage their own resources independently of their respective jurisdictions (provincial or municipal) once they have complied with certain conditions stipulated in the decree. These hospitals will be discussed more fully in the section dealing with changes in the public sector.

Policies reducing employers' contributions

The financial feasibility of the social security health system was threatened by the introduction of measures aimed at reducing the cost of labour by reducing employers' contributions to benefits. In March 1994, Decree 2.609 established that contributions for certain benefits could be reduced by different percentages, depending on geographical region. The effect on the funding of *obras sociales* was not uniform, revealing the incidence of other factors, particularly macro-level policies, on different sectors of economic activity. It should be noted that policies reducing employers' contributions underwent successive advances and setbacks in accordance with various levels of taxation and other variables at the macro level.

Decree 292/95 (14 August 1995)

Decree 292 has two objectives, to reduce excessive labour costs and assure the functioning of social security programs. This decree reinstated the reduction of contributions for those employers already benefiting under decree 722/25, and extended the privilege to all sectors of economic activity. In an attempt to make this reduction in labour costs compatible with basic health coverage for all, the decree guaranteed all *obras sociales* a minimum of US $30 (since 1991, 1 Argentine peso = US $1) per named beneficiary. Should an *obra social* collect less than this, the Fondo Solidario de Redistribución (FSR, solidarity redistribution fund), through the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration), will grant a subsidy to make up the difference. For persons over 60 years old, the guaranteed amount per beneficiary is US $36.

The resolution is important, not only because it guarantees minimum coverage and begins to recognize different risk levels, but also because it puts an end to the arbitrary distribution of subsidies on the part of the ANSSAL, a distribution that was historically motivated by political considerations.

Decree 492/95 (22 September 1995)

Decree 492/95 was motivated by pressure from trade unions opposed to the reduction of employers' contributions. Its main objective is to define a package of services that each *obra social* must guarantee its beneficiaries, and to ensure that each *obra social* has sufficient funding to provide such services. The resolution calls for the Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) and the Confederación General del Trabajo (CGT, general labour confederation) to designate a commission to be entrusted with establishing the package of services and setting the rules for its application. Also, the Decree raises the minimum guaranteed contribution to US $40 per beneficiary. Once the package has been approved, an *obra social* that finds itself unable to finance it has 60 days in which to propose a merger with one or more other organizations. Otherwise, the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration) has the power to order a compulsory merger.

Unification of jurisdictions — Superintendencia de Seguros de Salud

In December 1996, Decree 1615 took steps to rationalize policies. Its dispositions established the merger of different organizations having jurisdiction over the social security system, and created a new decentralized organization, the Superintendencia de Seguros de Salud (SSS, superintendence of health insurance), dependent on the Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action). The new state agency was administratively, economically, and financially autonomous, and was to be in charge of supervising, monitoring, and controlling agents' integration with the national health insurance system.

Specific provisions make the SSS responsible for verifying compliance with the basic health services package; the Programa Nacional de Garantía de Calidad (national quality guarantee program); the norms concerning self-managed hospitals; and the right of workers to chose their own *obra social.*

Reform of the Public Subsystem: Decentralization of the Hospital System

Transfer of hospitals

Since the mid-1950s, several policies have gone part way toward transferring public health services from the national jurisdiction to the provinces. These transfers of health institutions were based on fiscal criteria, and did not go hand in hand with any mechanism for financial compensation, or any impetus toward improving service quality. Beginning in the 1990s, new decentralization policies were set in motion, resulting in the transfer of 20 hospitals and some specialized institutions and social programs to the provincial level. Once again, the guiding motive was financial.

With few exceptions, the decentralization process from the national to the provincial level was not completed by transfers from the latter to the municipalities. In several cases, however, the provincial systems themselves developed a high degree of centralization, although the outcomes varied by province due to different conditions.

The nation has created hospitals endowed from their origin with a legislative structure that permits their decentralization to the microeconomic unit (hospital) level. These are highly complex hospitals possessing, for example, the power to formulate budgets and set salaries, similar to the self-managed hospitals created and regulated under Decree 578/93.

Decree 578/93 (1 April 1993)

This decree created a national register of self-managed hospitals (Registro Nacional de Hospitales de Autogestión) and made it compulsory for *obras sociales*, mutual aid societies, and prepaid insurance schemes to pay for services received by their beneficiaries from public health facilities.

To be eligible for incorporation into this system, hospitals were required to fulfill the following conditions:

- comply with all basic requirements established under the national quality program, and be authorized and categorized by a competent authority;
- receive funding from the applicable jurisdiction on the basis of production, efficiency, and type of population served; and
- supplement their incomes with fees-for-services from persons able to pay, and with funds from contracts signed with private health-insurance companies, mutual aid societies, and *obras sociales*.

Extra-budgetary revenues thus received are to be administered directly by the self-governing hospital. The hospitals were also authorized to use resources originating from the sale of services to create a structure of incentives based on recognition of productivity and staff efficiency, with a view to improving their administration. The future introduction of mechanisms for subsidizing demand was suggested, paving the way for the creation of public health insurance.

Experience acquired to date has been limited to a few institutions, and the outcome has not been uniform. In some cases, the enrolment of patients with coverage has excluded or limited the access of poor people to the system; in other cases, that risk has been explicitly removed through administrative mechanisms that effectively prevent discrimination. In any event, the additional resources obtained in this way are not great when considered as a percentage of the total budgets of these institutions.

Throughout the 1990s, three phenomena concerning the decentralization of the hospital system occurred simultaneously:

- The last of the national public hospitals was transferred to the provinces, achieving a decentralization that was merely administrative in its aims.
- The provincial health systems were reconfigured, with some centralization at the provincial level, but generally favoring decentralization toward the municipalities, thus giving rise to a heterogeneous set of provincial situations.
- A certain degree of microeconomic decentralization to the hospital level occurred in the form of the self-managed hospitals.

Evaluation

Effectiveness of reform — the underlying political conflict

It must be admitted that the effect of these measures on the existing system was small. One of the cornerstones of reform, deregulation of affiliation to the *obras sociales*, was blocked by firm opposition from the Confederación General del Trabajo (CGT, general labour confederation) Trade-union leaders defended maintenance of the status quo, chiefly because the financial resources of the *obras sociales* were an important source of economic and political power for them. Moreover, they had reason to believe that the labour movement may lose control of the system or be reduced to managing the portion with access to the fewest resources. Once freedom of choice between *obras sociales* came into effect, the door would be opened for competition with private insurance associations. It was feared that the latter would be able to attract affiliation from the higher-income stratum of the unionized population.

The fact that reform decrees are issued at intervals of 2 years or so is linked with cycles of improvement and deterioration in the relations between the government and labour leaders. In more than a few instances, the existing system of *obras sociales* was allowed to continue in exchange for approval of other measures that the government deemed more important to the reform program.

On the other hand, the other pillar of reform — liberalization of contractual measures affecting supply and demand of services — has had a significant impact on the greater part of the country. One has to ask, however, whether this is a consequence of reform measures or a movement initiated by entrepreneurs who have better opportunities elsewhere in view of financial crisis in social security. This point will be developed in the next section. Thus, a paradoxical situation has arisen whereby deregulation favors the competitiveness of the supplier as a result of fragmented demand, in the form of the survival of a number *obras sociales* controlling different levels of resources.

In 1995, several events affected the decision to push ahead with deregulation of the *obras sociales*, and revived the conflict with the CGT. The first of these was the Mexican crisis in December 1994, whose repercussions caused an upheaval in the Argentine financial system that lasted several months and prompted a new vote of confidence in the Convertibility Program. A second event was the beginning of a recessionary phase in the economic cycle that highlighted the difficulty of controlling public spending and awakened well-grounded fears of a fiscal imbalance capable of threatening the monetary stability achieved earlier. Economic leaders stressed the need to deepen state reform and, to this end, to resolve outstanding questions concerning relations between the national and provincial governments, and between the state and the trade unions. As a step forward in the matter, negotiations were held with the World Bank spurred on by the need to achieve efficiency in the administration of expenditures.

In the second half of 1996, talks between the government and union leaders deteriorated as a result of the Executive's decision to urge parliamentary sanction of the *Leyes de Flexibilización Laboral*, (labour flexibility laws). The CGT found all means of dialogue with the government blocked, and two general strikes were launched. The strikes received considerable public support given the government's loss of popularity due to its inability to reactivate the economy, to reverse staggering unemployment figures, to curb public spending or to control numerous cases of corruption and waste.

The government continued its drive to make labour relations more flexible and at the same time set deadlines for the deregulation of the *obras sociales*. Since January 1,1997, beneficiaries have been able to choose their *obra social*.

Social bases of the conflict — new and old actors in the health sector

Contemporary analyses of health reform emphasize the study of national cases, using conceptual and methodological schemes for comparative analysis. Also, the perspective frequently shifts from a consideration of the state's form and functions to a preoccupation with relationships between state and society viewed as social constructions, that is, the result of historical processes. Attempts to explain the peculiarities exhibited by reform policies in each context thus focus on the political and institutional forms that represent interests and construct political consensus. In this way, the processes of policy formulation and application cease to be considered the result of rationalizing instances, but rather the result of dynamic processes between actors. These dynamic processes explain the formulation and reformulation of power relationships peculiar to the health sector and stemming from the agreements, alliances, clashes, and confrontations between its chief actors and, in particular, from the identities they build around the cohesion and legitimization of the interests that they represent. Actors can be defined as:

> those individuals or groups occupying a strategic position in the decision-making system, and who are responsible, in the policy-forming process, for the functions of articulation of the cognitive field and the power field. In their role as mediators, it is they who define the issues of debate and the intellectual framework in which

> negotiations, alliances and conflicts sustaining decision-making take place." (Pierre Muller, taken from Merhy 1992, p. 46)

In the Argentine health services sector, the politically relevant actors have been, until very recently, large associations representing particular interests: the labour organizations, and the two large federations representing individual professionals and private hospitals, respectively.

To understand the changes in process, one must remember that competition between the political parties and these associations has been a relevant feature in Argentine politics since the 1940s. However, the last decade has seen the gradual weakening of the system by which associations represent their interests before the state. This is particularly noticeable in the changes that have come about in the relationship between the suppliers and users of services. Political analysts associate the weakening of corporate power with economic deregulation policies and with the decision to allow the rules of the marketplace greater play in the field of productive activity (Sidicaro 1995).

To understand the weakening of the corporations at a time of strong state influence on the economy, it must be borne in mind that policies aimed at opening up the economy have had different effects on different sectors, and this has precluded the possibility of each of the traditional corporations presenting a united front. This is not to say that power relationships have dissolved as a consequence of competition in the marketplace. Rather, economic interests will now be represented before the state through lobbying practices, which, once adapted to some of the traditional features of Argentine political culture, will find new ways to increase clients. This is another of the features characterizing the new system of alliances in the health sector.

The process was evident in corporations representing private hospitals even before contracting freedom between financing agencies and suppliers of health services was established. Faced with the financial crisis in the *obras sociales*, the institutions best able to compete began to offer more favourable contract conditions — in terms of costs and financial risks — to the *obras sociales*, either singly or collectively, thus giving rise to the first providers' networks.

The weakening of the Confederación General del Trabajo (CGT, general labour confederation), manifested itself differently, though it surely had the same origin. The leadership of the trade unions was affected in the 1990s by three interrelated processes:

- structural transformations that modified the composition of the labour force and increased the heterogeneity of wages and employment;

- changes in the political culture of negotiating work conditions that have resulted in a general drive toward collective agreements by company as opposed to labour specialty, which was the foundation of much of the trade unions' power; and
- antagonisms that have arisen between labour leaders adopting divergent positions with regard to the liberalization policies pushed by a government that purports to share their Peronist ideals but has relinquished, one by one, the traditional banners of the movement.

In this context, the relationship between the government and the trade unions is being continually redefined. Control of the *obras sociales* is frequently used as a bargaining chip in the face of other issues that are perceived as more pressing to — or less reconcilable with — the reform process being carried out by the Ministerio de Economía de la Nación (ministry of the economy). In this way, the structural features that would redefine the relationship are continually subject to changes based on matters of the moment. Another weighty factor at the political level is the power struggle for the presidential succession in 1999, and the apparent intention of the candidate most likely to win to reinstate the traditional alliances of the Peronist movement, with Menem's support.

Thus, under Menemism, the labour movement has fragmented, giving rise to two groups opposed to the CGT: the Movimiento de los Trabajadores Argentinos (Argentine workers movement) and the Congreso de los Trabajadores Argentinos (Argentine workers' congress). However, some components of the labour movement, those closest to the government's liberal tendencies, have radically transformed their organizations into what has been called sindicalismo de negocios or business unionism.

Changes in the union movement go beyond the weakening the negotiating capability of the CGT, however. The labour leaders best able to profit from the privatization of public enterprises or the deregulation of services production have begun to incorporate entrepreneurial functions into their traditional activities The following are examples of positioning by trade unions in the face of changes affecting their place in the scheme of things: management of *Programas de Propiedad Participada*, shared ownership programs, in privatized public enterprises; organization of micro-enterprises for petroleum prospecting and electric power generation; and participation in companies that administer retirement funds or health care management organizations.

The CGT's opposition to the deregulation of the *obras sociales* did not therefore come about in a context of institutional paralysis. Despite confrontation with the government at the political level, a large number of them have begun to develop a new managerial capability with a view to adapting to the new scenario. At present, their strategies are aimed in three main directions.

- An important group of *obras sociales* — 73 institutions representing about 5 million beneficiaries — have opted for the advantages offered by the *Programa de Reconversión del Sector Salud* (health sector reform program), financed by the World Bank.
- A second group — made up of smaller entities unable to form an adequate risk pool individually — have begun merging or forming federations. In the first case, that of a merger, the result is a new *obra social*. In the second case, a federation, the entities retain their legal individuality but pool the collection and administration of their financial resources.
- Lastly, some *obras sociales*, individually or in groups of three or more, are associating with local or foreign companies to form a new association, under the legal form of a stock company or something similar, to act as health care management agencies for all their beneficiaries, and to provide an alternative in a deregulated situation.

To further complicate the situation, since 1994 of multinational capital of varied origin to the health services system. Companies such as Amil, the Excel Group, The Principal, Provida, Swiss Medical Group and others have acquired local health service institutions or have formed joint ventures for the future management of such institutions. They have also entered the field of private insurance, or have acted as consulting agencies dedicated to improving the management of financing institutions, individual providers, or providers' networks. Another field that they have entered is health services administration, by associating with or absorbing existing institutions, or by creating new ones.

Conclusion

The crisis that affected all levels of society throughout the 1980s, culminating in the hyperinflation of 1989, signaled the depletion of some of the country's fundamental institutions. Recovery in the 1990s came about partly as a result of rethinking the logic governing them. At the economic level, this was reflected in the results of the policies for liberalizing the economy and, in particular, one of the most effective instruments of these policies, the Convertibility Plan. At the political level this led to state reform, which has not yet been completed.

The health services system could not remain untouched by the financial crisis and the transformations that followed. In the public sector, the reduction of fiscal spending aggravated long-standing conditions of decay and decadence. These public services, intended for the poor population, found their clientele increased by contingents of "new poor": members of the lower and middle classes suffering the consequences of unemployment, informal labour, self-employment, and precarious labour relations. The *obras sociales* were affected by the same processes, through a decrease in the population covered and an attendant reduction of contributions; evasion on the part of contributors; and increased disagreement within the system as to the distribution of funds.

To these factors originating outside the health sector, must be added others equally or more important. They relate to longstanding deficiencies or distortions in the health services organization, including: extreme fragmentation and heterogeneity in the *obras sociales*; the reluctance of the state organizations concerned to put them in order; an overloading of public services due to the demands of those with insufficient coverage; the predominance of the private sector in the supply of services; the existence of methods of payment that encouraged oversupply and overcharging; and the expansion of installed capacity and a supply of technology that exceeded the ability to pay. All of these were manifestations of the exhaustion of the organizational mode prevalent up to that time.

The state's response was expressed both in terms of freedom to sign contracts and deregulation in the area of social security, and in terms of localization and decentralization — at institutional and territorial levels — in the policies applied to the public sector. Contracting freedom between financing organizations and providers of health services was quickly adopted by the private sector in response to an oversupply of services. The corporations traditionally predominant in this sector quickly lost the oligopoly that they had enjoyed through control of contracts with the *obras sociales*. New forms of intermediaries such as service management agencies, transient company mergers, and suppliers' networks undertook the management of risk contracts incorporating per-capita methods of payment. New forms of services supply were incorporated and cost-containment strategies that placed family physicians or general practitioners in a "gatekeeper" role, were tried out. Financing possibilities were enlarged through the expansion of private insurance organizations.

On the demand side, reform encountered obstacles that were harder to surmount because they were rooted in conditions outside the health sector, mainly the confrontational relationship between the state and the trade unions that had existed since the beginning of the 1950s. Interest on the part of reformers — part of the government and the World Bank — centered on eliminating the "captive population" of the *obras sociales* by allowing union members freedom of choice between institutions administering social security contributions. In this way, it was hoped to stimulate competition, to generate incentives to reduce administration costs, and to offer better quality health care. The refusal of the Confederación General del Trabajo (CGT, general labour confederation), which uses the *obras sociales* as a bargaining chip with the government whenever discussions arise concerning production policies, employment policies, or the survival of leaders' privileges, has blocked the application of the reform decrees during the last 3 years.

The process has been more complex within the associations of suppliers, because these are not groupings of business organizations, but groupings of institutions having mixed political and trade-union bases. Their adaptation to the new contracting conditions has been accomplished by means of different strategies, such as the formation of private insurance companies, the purchase of private hospitals, the installation of ambulatory diagnostic and surgical centres, and the introduction of the associations into existing supplier networks. In this way, they have attempted to assure their members a place in the supply of services.

Private hospitals, *obras sociales*' hospitals, and to a lesser degree, independent professionals continue to hold a predominant place in the structure of the health services system, particularly in matters relating to the regulation of supply conditions; the incorporation of technology; changes in the way services are organized, and in the control of supply conditions. Now, however, the regulation of supply conditions is no longer accomplished through a centralized entity guaranteeing equal access to demand by all members of the corporation, but rather through the dynamic interplay of business competition in quest of contracts with the *obras sociales*.

Chapter 3.
Reorganizing the Health Care System in Argentina

Susana Belmartino

Introduction

This chapter will describe the fundamental features of the health services system (HSS) in Argentina, with emphasis on its organization, financing and service delivery. The first part will cover the structural features of the system and the dynamic processes that it has undergone in recent years, in order to provide a general understanding of health needs and available resources. It will also give a socio-demographic and epidemiological profile of the population; provide information on health expenditure by source of financing and the proportion of the population covered by each subsystem; and describe the institutions in charge of financing and providing health services, including the evolution of inpatient and outpatient facilities in the three subsystems that make up the HSS.

The second part of this chapter outlines two organizational models of the system. The first was in effect during the 1960s and 1970s, and went into a deep crisis at the beginning of the 1980s. The second is the result of changes that occurred because of that crisis, which have profoundly changed the relationship between financing institutions and health care providers, to the extent of lending support to the hypothesis that a new model is under construction.

Structural Features

Socio-demographic features

According to the 1991 Population and Housing Census, the total population of Argentina is over 34 million, 85% of them living in urban areas. Indeed, almost 50% of the population is concentrated in the Federal District and the Province of Buenos Aires. Trends in certain socio-demographic indicators can be seen in Table 1.

Of the total population, 46% are under 25 years of age, 40.8% are between the ages of 25 and 59, and the remaining 13.1% are 60 or older. The economically active population (EAP) is 12.2 million, of which 54.2% are employed in the service sector, 13.2% in farming, 10.9% in construction, and 21.7% in industry. The EAP has remained at about 36% or 37% during the last 6 years. In contrast, unemployment has increased steadily from 6% between 1989

Table 1. Socio-demographic indicators, Argentina, 1970 and 1990.

	1970	1990	% increase
Urbanization rate[a]	80.30	87.20	8.59
Literacy rate[b, d]	92.90	95.00	2.26
Life expectancy at birth[b, e] (years)	68	71	4.23
Infant mortality rate[c, f] (neonatal and post-neonatal per 1 000 live births)	62.00	22.30	-64.03
Mortality rate[c, e]	9.36	7.69	-17.84
Birth rate[b] (gross for 1 000 inhabitants)	23.00	21.00	-8.70
Fertility rate[b]	3.10	2.80	-9.68

Sources: [a] Lindenboim (1997). [d] Anuario Estadístico de la República Argentina, 1979–80.
[b] World Bank (1993). [e] UNDP (1993).
[c] *MSAS* (1996). [f] *MSAS* (1985).

and 1991, to 17% in 1996, according to the national household survey and the biannual survey (INDEC 1996) of the Instituto Nacional de Estadísticas y Censos (INDEC, national institute of statistics and censuses).

Over 6 million Argentineans, or over 19.3% of the total population, are defined as living in a situation of structural poverty, that is, in households unable to satisfy their basic needs. Of the poor population, 23% are women of reproductive age and their children (INDEC, National Population and Housing Census, 1991.) With regard to the epidemiological profile of the population, the main causes of death are heart disease (22.7%), malignant tumors (14.8%), and cerebrovascular diseases, as can be seen in Table 2.

Table 2. Principal causes of mortality, Argentina, 1980 and 1994.

	1980		1994		
	Mortality rate (per 10 000 inhabitants)	%	Mortality rate (per 10 000 inhabitants)	%	% increase
Cardiovascular disease	25.8	29.9	22.7	29.5	-1.34
Malignant tumor	13.9	16.1	14.8	19.3	19.88
Cerebrovascular diseases	8.0	9.3	7.2	9.4	1.08
Other	**38.6**	**44.7**	**32.2**	**41.8**	**-0.06**
Total	86.3	100.0	76.9	100.0	

Source: MSAS (1996).

Expenditures

According to World Bank figures, public expenditure on social programs has been growing under the Convertibility Plan, both in absolute and relative terms. Consolidated public social expenditures increased from 16.4% of gross national product (GNP) during the period 1984-1988, to 17.3% during the first Menem administration (1989-1994), to reach US $51.4 billion or 18% of GNP in 1994 and 18.3% in 1995. Consequently, overall social spending as a share of total public expenditure rose significantly from 49.5% during the period 1984-1988 to 67.2% in 1994. Of the total amount devoted to social expenditures, 11% — or 2.15% of GNP — was destined to finance health services supplied by the public sector. The sources of financing for the other subsystems within the HSS, and their relative share of the total expenditure on health between 1970 and 1995, are shown in Table 3.

Table 3. Distribution of health expenditure, 1970–95.

Year	Public sector (%)	*Obras sociales* (%)	Out of pocket (%)	Total expenditure (US$ millions)*	% of GNP	Per capita
1970	19.5	22.8	57.7	9 755.0	7.75	417.6
1980	30.1	35.8	34.1	10 779.2	6.73	381.8
1985	22.7	39.2	38.1	11 910.3	8.24	389.8
1991	20.2	32.4	47.4	13 188.0	7.29	404.2
1995	23.6	34.9	41.5	19 230.0	9.00	565.5

Source: Cetrangelo, O. et al. (1992), World Bank (1995)*. In the total expenditure column: US$ (millions). Values are adjusted according to combined price indexes (consumer and national wholesale non-farming) at prices of March 1992.

These values must be compared cautiously, however, because they come from different sources. Nevertheless, the data do illustrate certain trends. For example, the 1970 distribution reflects the situation before the *obras sociales* system became generalized. Consequently, a larger proportion of spending came directly out of the pockets of consumers. The values for 1980 reflect the stage of higher coverage by *obras sociales*, with a significant drop in out-of-pocket spending. The values for 1985 and 1991 show a reversal of the trend as a result of the financial crisis in the *obras sociales*. Private spending increased either directly or through the purchase of private insurance or additional insurance (co-insurance), or to cover extra-billing by physicians at the time of providing services.

It must also be pointed out that public expenditure on health decreased between 1980 and 1994 in nominal values, as a percentage of total expenditures, and as a percentage of GNP. The values for 1995, obtained from estimates made by World Bank officials, show a recovery in public expenditure; however, these figures have not been accepted by other analysts, who go so far as to double the out-of-pocket estimates issued officially (Tafani 1996).

The breakdown of health expenditure shows that most of the public spending came from the provincial governments and the Federal District (see Table 4).

Table 4. Estimated health expenditure — 1995.

	US$ (millions)	% of total
Total	19 230	100.00
Public Expenditure		
National	410	
Provincial governments and Federal District	3 370	
Municipalities	760	
Subtotal	4 540	23.61
Social Security Expenditure		
Obras sociales (ANSSAL)	2 560	
PAMI	2 380	
Provincial and municipal *obras sociales*	1 380	
Autonomous *obras sociales*	390	
Subtotal	6 710	34.89
Family expenditures		
Indirect	3 760	
Direct	4 220	
Subtotal	7 980	41.50

Source: Local office of World Bank.

Population coverage

In 1995, 58.4% of the total population of Argentina was covered by either a social security scheme or by private insurance, the latter covering only a small fraction of the ensured population (Table 5).

These values must be taken as estimates, however, because the state agencies themselves claim not to know the actual number of *obras sociales*

Table 5. Distribution of population covered by insurance according to financial source, 1995.

Type of coverage	Beneficiaries covered (millions)	% of population	% of total population
Social Security	17.613	88.45	51.65
National *Obras sociales*	8.491	42.64	24.90
Provincial *Obras sociales*	5.179	26.01	15.19
PAMI	3.943	19.80	11.56
Private insurance	2.300	11.55	6.75
Total population covered by insurance	19.913	100.00	58.40

Source: World Bank (1995)

beneficiaries and no precise information is available on private insurers. Also, the total value is not exact due to an overlap in coverage between *obras sociales* and private insurance, and even between different *obras sociales*.

The difference between the total population and the population covered by either compulsory or voluntary insurance is considered to be the population covered by the public subsystem, which is open to the whole population. However, some analysts consider that 5% of this number consists of high income-earners who pay for health services directly out of their own pockets.

Subsystems

The division of health services into three subsystems, public, private, and social security, has a dual basis. It is based on the ownership or jurisdiction of the respective health care services, and on the source of financing and the mechanisms that link payers and providers. Statistical information is collected and elaborated on the basis of the three subsystems, as reflected in the description given in the first part of this section.

The transformations that have taken place in organization of the health care system are basically linked to the relationship between the financing and provision of services. To facilitate a schematic presentation of these transformations, I will consider the three subsystems, but use a single classifying criterion, namely source of financing. Thus, the public system is one in which resources came from taxes, the social security system is financed by compulsory contributions, and the emerging private system is funded through voluntary insurance schemes. The relationship between financing and provision is integrated in the case of the public system and contractual in both the compulsory and voluntary insurance subsystems.

The three subsystems identified above are based on the classification used in a report issued by the Organisation for Economic Co-operation and Development (OECD 1992), which contains a comparative analysis of health care reform in a number of European countries. The categories applicable to Argentina are as follows:

- Compulsory insurance model: Resources are collected and managed by the *obras sociales*, and feature provision of services by contract: compulsory health insurance that involves direct payments, under contract, from the insurers or third-party payers to the providers of services rendered to insured persons. In this model, the providers are often independent and the contractual payments to them are by capitation or on a fee-for-service basis.

- Public integrated model: This model corresponds to services financed and provided by institutions dependent upon different state organizations. Resources come out of general taxation and payments to providers are by salary and prospective budget. Government is the principal insurer and the major provider. Benefits are supplied to patients in kind, often free of charge.
- Voluntary insurance model with provision of services by contract: This model corresponds to institutions engaged in organizing voluntary health insurance with direct payments, under contract, from the insurance company or third-party payers to the providers of services rendered to insured persons. Under this model, the providers are often independent and the contractual payments made to them on a fee-for-service basis.

Social security

Obras sociales are group insurance schemes based on the occupation of their beneficiaries. They function as sickness insurance funds, financing health care services for employees and their immediate families. Those under national jurisdiction were legally constituted by Law 23.660 of 1989 and its regulating Decree 576/93. These dispositions have undergone partial modifications through decrees sanctioned in 1993 and 1995, the main aspects of which were discussed in the previous section. The *obras sociales* under provincial jurisdiction are ruled by specific laws.

Obras sociales are semipublic, because their creation requires authorization by the state, which has the means to intervene in their administration. They must pursue public ends and they exercise public authority, as expressed in the compulsory nature of their affiliation and their right to apply sanctions.

The 281 *obras sociales* at the national level are the central agents of the health insurance system and cover 48.21% of the population ensured under the compulsory insurance system (Local Office, World Bank). They are subject to national jurisdiction through the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration). The 23 provincial *obras sociales* cover 29.41% of the population, mainly employees of the provincial public sector and their dependents. Their source of financing is income-related contributions by employers and employees. In the case of *obras sociales* under the national regime, contributions amount to 8% of payroll. Provincial contributions vary between 7% and 12.5% of payroll. The Instituto Nacional de Seguridad Social para Jubilados y Pensionados (INSSJYP, national social security institute for retirees and pensioners) is under a special regime, and is commonly known by the initials corresponding to its Programa de Atención Médica Integral (PAMI, comprehensive health care program). It covers some 22.4% of the population under the compulsory insurance system, and its resources come from contributions from active and retired workers, varying between 3% and 6% of their earnings.

The fundamental features of the social security system are its compulsory nature and its organization according to the beneficiaries' occupation. Contributions from both employers and employees are channelled to the respective *obra social*, trade union, and so forth. Despite the existence of a large number of institutions, both beneficiaries and resources are concentrated in a relatively small number, meaning that many are not financially viable. Out of 281 institutions, 30 account for 73% of the beneficiaries and 75% of the resources.

Thus, the average revenue per beneficiary varies widely among *obras sociales*. Some of them have incomes of less than US $5 per beneficiary per month. Others take in over US $80 per beneficiary per month.

The Fondo Solidario de Redistribución (FSR, solidarity redistribution fund), administered by ANSSAL, was instituted by Law 18.610/70 with a view to reducing this kind of imbalance between *obras sociales*. It was unable to fulfill this function, however, for reasons generally attributed to political pressure, and contributes only 0.9% of the total resources of the system. Extreme politicization transformed the subsidies distributed by the Instituto Nacional de obras sociales (INOS, national institute of *obras sociales*) and ANSSAL into resources destined to co-opt or reward the political clientele.

Given the sharp differences in average income levels across *obras sociales*, there are wide disparities in the comprehensiveness of the services that they provide. Expenditure on health services in the higher-income *obras sociales* is six times that in the lower-income group; the annual number of consultations per beneficiary varies between 1.9 and 8.4, and expenditure on pharmaceuticals by "rich" *obras sociales* is 13 times that of "poor" ones.

In spite of their large total expenditure, the services provided by the *obras sociales* have become targets for criticism on several counts. The health care orientation is fundamentally curative, featuring highly specialized services, technology that is not always suited to the demand profile, and heavy reliance on inpatient care facilities. In general, the financing organizations have not participated in the development of service systems, confining themselves to covering the range of services supplied by the marketplace, with no other limit than their own financial capability.

Public services subsystem

The services of the integrated public subsystem are financed through resources from the national budget, and managed by the national, provincial, and municipal governments. The Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) is the organization in charge of regulating the entire health services system. Its functions are to set norms, regulate, plan, and evaluate all aspects of health care, including promotion, prevention, treatment, assistance, and rehabilitation. It directly manages five specialized hospitals and special programs such as immunization, maternal and child health care, AIDS, and sexually transmitted diseases (STDs). It participates, through the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration), in the definition of policies concerning the *obras sociales*.

Each provincial government is responsible for the health of the province's inhabitants due to a constitutional power not delegated to the national government or the municipalities. This power is exercised through their respective ministries of health, which in most cases have a centralized structure and a specific budget. In some provinces, the municipalities manage health centres dispensing primary care services and may even have hospitals under their jurisdiction. These services are financed by resources from the municipal budget, and subsidies or transfers from the provincial or national government. The provinces play a considerable role in the health services sector, as more than 75% of public expenditure on health comes out of their budgets. Over the last decade, they have expanded their range of action and organized the sector in accordance with their own criteria and methods.

Figures on health care expenditures by level of government are given in Table 4. In provincial jurisdictions, the expenditure on hospitals amounts to more than 85% of the total. The remainder corresponds to primary care and special programs.

The public hospital is the cornerstone of the public services subsystem. It provides care to the poor who have insufficient or no medical coverage; subsidizes the *obras sociales* by providing services to their beneficiaries without charge; and occasionally serves higher-income-earners who are attracted by the reputation of a particular institution or its medical personnel. The public hospital is also responsible for providing essential health emergency services; training professionals to the graduate and postgraduate level; and biomedical research.

Nevertheless, the public hospital today epitomizes all the contradictions in the health care system as a whole. It exhibits serious structural deterioration and managerial inefficiency; a high degree of administrative centralization at the provincial level; rigidity in its staffing structure and labour relationships; no adequate system of incentives; inadequate information systems on which to base decision-making and control; serious deficits in facilities and equipment maintenance; and a system of management ill-suited to its size. Its budgets, in most jurisdictions, follow the traditional pattern of assigning resources by function or by set of practices. Hospital budgets are often subject to political pressure.

Current methods of financing are characterized by the following features:

- use of a global budgeting system, with no mechanisms for planning, implementation, or control;
- wages and salaries for hospital personnel, representing about 85% of hospital expenditure, come directly from central administration; and
- no identification of patient coverage, which makes it impossible to determine whether a given service is accessible to the uninsured population or to evaluate the extent to which the hospital is fulfilling its mission to provide services to the poor.

Private insurance

Voluntary insurance plans (*empresas de medicina pre-paga*) are provided by over 200 organizations, cover more than 2 million people, and pay out more than US $1.5 billion annually. The 72 largest companies account for about 70% of the market, cover 1 740 million beneficiaries and report earnings of US $1.13 billion. They are profit-making organizations that seek clients from among the higher-income segment of the population. The coverage they supply is limited, and different plans are priced according to the level of risk they cover. Contracts establish the period of coverage and preexisting conditions are not covered.

In addition to the private plans, there are more than 3 000 mutual aid societies providing health care services to one million beneficiaries for an amount estimated at US $500 million.

Private profit-seeking insurance companies evolved out of initiatives by groups of professionals or private hospitals, and some of them have reached a significant size. According to the Ministerio de Trabajo y Seguridad Social de la Nación (MTSS, ministry of labour and social security), the majority are organizations designed on a business model with professional management (MTSS 1995). They base their offer on levels of excellence in given areas, and on efficiency, image, and marketing.

According to an evaluation by the World Bank (1995a), existing private insurance schemes constitute a very heterogeneous system with an enormous number of organizations, extremely high operating costs, and little transparency in the areas of competition and consumer protection. There are currently no effective mechanisms to protect users from bearing the brunt of increasingly fierce competition. Its flexible structure undoubtedly allowed the private insurance system to function dynamically as a marginal entity within the health care system in its initial stages. However, this flexibility may now represent an obstacle to maintaining and developing an integrated, transparent, competitive, and universal market.

On the other hand, domestic and international economic conditions in recent years have favoured the appearance of foreign capital in the field of private insurance services. Several of the most important health insurance companies have been sold to American, Swiss, or Latin American companies. Financial groups that entered the market of the *Administradoras de Jubilaciones y Pensiones* (retirement and pension fund administration firms) and later organized the *Administradoras de Riesgos de Trabajo* (occupational hazard administration firms), are now looking to expand into the health insurance market via the deregulated *obras sociales*.

To date, regulatory intervention by the state has been minimal. No regulations exist to govern exclusion or refusal to cover pre-existing conditions. Nor are there any standards with regard to minimum capital, reserves, or reinsurance that insurance services must meet to protect the covered population. All these concepts are part of the debate associated with deregulation of the *obras sociales* and, at present, the future standards for regulating these enterprises are being discussed in congress.

Organization and provision of health services

The Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) is the organization in charge of standardizing, regulating, planning, and evaluating health care activities in the country. It is also in charge of producing epidemiological statistics. Through the *Programa Nacional de Estadísticas en Salud*, national health statistics program), it collects the scant information available on health services distribution. This program has recently published the *Guía de Establecimientos Asistenciales en la República Argentina* (MTSS 1995), a guide to health care establishments in the country that traces the supply of services and its evolution over the past 15 years.

Institutions with and without inpatient services

Between 1980 and 1995, inpatient care institutions increased by 10% while ambulatory facilities increased by 100%. A considerable number of these establishments are owned by the private sector, which doubled its facilities from 4 039 to 8 873 during the same period. At the same time, the number of facilities that depend on the *obras sociales* decreased from 364 to 222, while the number of public facilities increased from 4 648 to 6 971. By 1995, 98.5% of the total number of institutions were either publicly or privately owned, with private sector ownership accounting for 55.2% of inpatient and ambulatory facilities.

A considerable change has also occurred in the distribution of each kind of service. Whereas in 1980, the number of ambulatory facilities was double that of inpatient facilities, the proportion has now grown to 4 to 1. This is particularly noticeable in the public sector, where a 3 to 1 ratio in favour of outpatient facilities has now changed to almost 5 to 1, bearing evidence of the emphasis on primary care centres. At the municipal level, ambulatory facilities have increased from 19.8% to 30.8% of the total number of institutions.

Moreover, in spite of the increase in the number of public facilities in both categories, the sector's proportion of outpatient facilities has fallen from 57% to 45% while its proportion of inpatient facilities has fallen from 39% to 37%. The private sector has taken up the slack, increasing its share of outpatient facilities from 38% to 54% and inpatient facilities from 57% to 61%. The private sector has thus increased its share of inpatient facilities and surpassed the public sector in terms of ambulatory institutions. The proportion of public and private ownership for all facilities can be seen in Table 6.

Table 6. Hospitals and health centres by subsector, Argentina, 1980 and 1990.

	1980		1990	
Subsector	n	%	n	%
Public	4 648	51.35	6 990	43.46
Social security	364	4.02	222	1.38
Private	4 039	44.63	8 873	55.16
Total	9 051	100.00	16 085	100.00

Source: compiled by author from various sources.

Beds

The number of beds (public, private and *obras sociales*) increased by about 10 000 units between 1970 and 1980, and by a similar number between 1980 and 1995. In the first period, the increase occurred in private and social security institutions; in the second, it occurred exclusively in the private sector, as beds

Table 7. Beds in hospitals by subsector, Argentina, 1970, 1980, and 1995.

	1970		1980		1995	
	n	%	n	%	n	%
Public sector	96 688	73.0	91 034	62.48	84 176	54.05
Private sector	30 095	22.5	46 611	32.00	67 198	43.15
Obras sociales	4 977	3.7	8 045	5.52	4 375	2.80
Total	131 760	100.0	145 690	100.00	155 749	100.00

Source: compiled by author from various sources.

owned by the public sector and the *obras sociales* steadily decreased. These data are illustrated in Table 7.

The following are among the causes cited to explain the decrease in the number of public sector beds:

- the adoption of an orientation toward a health care model based on primary care;
- declining budgets in the public sector due to the fiscal deficit and the measures adopted to overcome it; and
- more judicious use of the sector's financial resources by introducing focused and demand-driven policies.

With regard to the *obras sociales*, one must remember that they lost a considerable number of their members due to layoffs in the metalworking sector and the dismantling of a large number of railway branch lines. These events affected two of the trade unions that had developed services of their own. To this must be added the newly introduced permission to contract with the private sector under conditions such as capitation, which allowed the risk to be transferred from the payer to the provider, thus converting the maintenance of facilities into a fixed cost with limited strategic value.

Human resources

As there is no continually updated national register of health professionals in Argentina, one cannot be certain of the actual number of physicians. Nevertheless, the Asociación Médica Argentina (Argentine medical association) estimates the number of physicians at 87 000, giving a national ratio of one physician per 370 inhabitants. In 1958, 1959, and 1980, the estimated numbers of doctors were 24 000, 54 000 and 69 000 respectively. Physicians are distributed unevenly between the capital and the provinces, and between rich and poor provinces. According to the 1980 census, there were 47 doctors per 10 000 inhabitants in Buenos Aires, whereas there were between 15 and 20 doctors per 10 000 inhabitants in 10 provinces, between 10 and 14.9 in other provinces, and fewer than 10 in the four north-eastern provinces.

In 1980, the health sector employed some 290 000 persons, or about 2.9% of the economically active population (EAP). Official estimates for 1985 indicate that the workforce had increased to about 400 000 persons, or 4% of EAP. The distortion in the distribution of the workforce is evident in the fact that at that time there were 90 000 physicians and only 41 000 nurses working in the health care services. The complete distribution is given in Table 8.

Table 8. Human resources in health care, 1985.

Profession	Number
Physicians	90 000
Dentists	22 000
Pharmacists	29 000
Biochemists	9 500
Midwives	4 000
Physiotherapists	13 000
Psychologists	25 000
Nurses	16 000
Nursing assistants	25 000
Technicians	90 000
Administration employees	95 000

Source: *OPS/OMS* (1990)

Transformations in the Health-Service Systems — Organizational Models

Organization of the health services system between the 1960s and 1980s

This analysis will consider only two subsystems in the organization of the health services system in Argentina, because the practice of private insurance only began to intensify in the second half of the 1970s, as a complement or supplement to the social security system. The health services systems (HSS) was composed of a model financed by compulsory social security contributions (*obras sociales*), with the provision of services by contract, and a model financed through taxation (public health system), offering a comprehensive range of services. The first covered close to 75% of the total population, made up of salaried workers and their dependants, and the second covered about 20% of the population, mainly persons with low incomes and with insufficient or no social security coverage. A small percentage of the population paid for their health care directly and the middle-income segment of the population was covered by various forms of private insurance, as a supplement to social security.

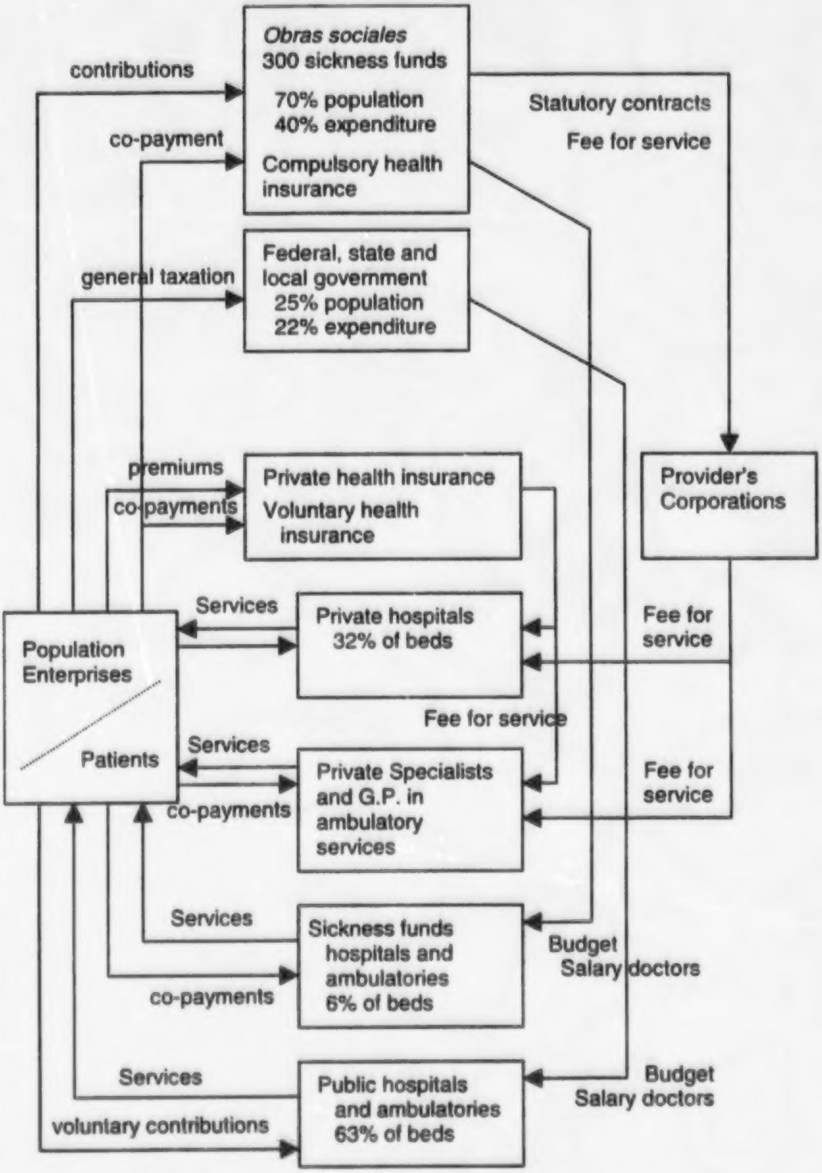
Providers have been classified as follows: public medical centres with salaried doctors; public hospitals with salaried doctors; independent general practitioners and specialists; and private for-profit hospitals, usually employing physicians on a fee-for-service basis. The *obras sociales* paid the association representing independent professionals and private hospitals for services provided to their members. Public services received global budgets and paid their doctors full- or half-time salaries.

Relationship between third-party payers and providers

The relationship between the *obras sociales*, on the one hand, and physicians in independent practice and private hospitals, on the other, was highly formalized. The doctors were organized into associations at the local level. The associations were organized into federations at the provincial level. And, the provincial-level federations were grouped into a third-level federation at the national level, the *Confederación Médica*. All licensed physicians were entitled to be providers of services to *obras sociales*' beneficiaries through their respective associations. Contracts were signed between *obras sociales* at the national, provincial, or local level and the respective associations and federations. The same scheme was applied to relations between *obras sociales* and private hospitals, similarly grouped into associations and federations.

The contracting methods were regulated by the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration) or its predecessor Instituto Nacional de *Obras sociales* (INOS, national institute of *obras sociales*). Contract terms and conditions, and forms of payment for services, were established at the national level and applied uniformly throughout the country. By law, the amounts charged for each service had to be established periodically through formalized agreements between representatives of the providers and the *obras sociales*, with state arbitration in case of conflict. In practice, it was the state that determined the amounts, which were recorded in the Nomenclador Nacional de Prestaciones (national nomenclature of medical fees for services). This list has become the main instrument regulating the service model, because the prices set favoured curative, highly specialized and technology-intensive care. Fees were established on the basis of an accounting unit, the *galeno*, which was used to adjust payments to inflation. It was also used to modify the relative values of various interventions, with a view to encouraging some and discouraging others.

Figure 1. Argentine health services system 1960–1980.


Obras sociales
300 sickness funds
70% population
40% expenditure
Compulsory health insurance
contributions
co-payment
Statutory contracts
Fee for service
Federal, state and local government
25% population
22% expenditure
general taxation
premiums
co-payments
Private health insurance
Voluntary health insurance
Provider's Corporations
Services
Private hospitals
32% of beds
Fee for service
Population
Enterprises
Patients
Fee for service
Services
Private Specialists and G.P. in ambulatory services
co-payments
Fee for service
Services
Sickness funds hospitals and ambulatories
6% of beds
co-payments
Budget
Salary doctors
Services
Public hospitals and ambulatories
63% of beds
voluntary contributions
Budget
Salary doctors

The predominant method of reimbursing providers was the fee for service. One of the assumptions underlying the model was that professional associations would monitor the quality and volume of services supplied by each physician and, if necessary, apply appropriate discipline. This did not happen, however, nor was any form of control exerted on the part of the financing institutions. Volume was determined mainly between patients and doctors, under circumstances that provided neither with any financial incentive to economize. At the individual level, doctors competed for volume and income.

There was similarly relatively little control over expenditure on pharmaceuticals. The wholesale price of drugs was set unilaterally by the pharmaceutical companies, and prescriptions were decided by each doctor in the absence of incentives to be economical.

Compensation for professional services rendered in private hospitals was based on a rate per day per bed, as set by the national schedule. Added to this was payment for different procedures involving the use of technology, on a fee-for-service basis. Here also, there were no effective controls on volume.

Under these circumstances, the only possible option for cost-containment was cost-sharing by the patients. This led to an increase in the use of and consequent increase in the volume of private services, which was one of the main determinants of the financial crisis in the *obras sociales*. Third-party financing and fee-for-service payments led to strategies of over-treating and over-charging on the part of individual providers.

The relationship between insurers and providers was ruled by similar conditions in the private insurance sector. A small number of *obras sociales* developed their own health care services, whereby the transfer of funds was accomplished through budgets and professionals were paid a salary. In the public subsystem, financing was also done through global budgets and salaried doctors. The difference in the amount of payments when compared with the private sector was considerable. On the other hand, failure to keep up with the latest technology, along with a general decrease in available resources, weakened the public subsystem's ability to attract medical students for postgraduate training.

Supervision at the central level was limited to bookkeeping, with no recourse to performance controls that might have rewarded efficiency and productivity. Budgets for services were renewed annually and remained a more or less constant percentage of fiscal resources. Each provider's allocation was made without reference to parameters that take into consideration the expected demand or a predefined development program.

Relationship between patients and providers

Under the compulsory, contractual *obras sociales* system, patients were covered for services that were predominantly curative, whether provided in an ambulatory or inpatient facility. Some preventive activities, such as prenatal and child care, were compulsory for all *obras sociales*. Nevertheless, they followed the directives according to their own interpretation of priorities or availability of resources. Vaccination was generally supplied outside the system by institutions in the public subsystem.

Patients enjoyed freedom of choice of physician. They could, without being referred, choose to see a general practitioner, an independent specialist, or a specialist working out of a private hospital. Ambulatory-care practices were well equipped and had ample access to the most advanced diagnostic and therapeutic services.

Differences in the availability of resources and inefficiency in their management affected access to health care by beneficiaries of some *obras sociales*. This situation became apparent in the different utilization rates between ambulatory and inpatient care services, differences that could not be explained by either the epidemiological profile or the consulting habits of the population.

The public subsystem catered to the needs of the poor or "medically indigent" population. The concept of "medically indigent" is relatively ambiguous. A population is considered indigent if it is not part of the formal labour market and therefore not covered by an *obra social*, either directly or through a family member. Second, individuals are considered medically indigent if they have insufficient medical coverage for certain complex procedures and must therefore have recourse to the public sector, or if they are unable to meet the out-of-pocket expenses required at the time of receiving a service.

In theory, the activity of the public subsystem was regulated by means of plans and programs; in practice, however, it was governed by spontaneous demand. Since the only information collected by these facilities was related to production indicators, it was impossible to develop plans or programs based on population criteria, detect unmet needs, measure accessibility, or evaluate the system's performance.

Relationship between population and third-party payers

As has already been pointed out, at the height of their expansion, the *obras sociales* covered close to 75% of the population, comprising the entire wage-earning population and their dependants. Affiliation with an *obra social* was determined by a member's occupation. This made for a fragmented system, which weakened the possibility of forming an adequate risk pool. Nevertheless, it had the advantage of eliminating risk selection (discrimination on the basis of risk) by guaranteeing coverage to all beneficiaries under equal conditions, and without regard to their respective contributions.

Obras sociales were required by law to offer a set of general and specialized services. Nevertheless, in this aspect (as in others), the system was incapable of enforcing the rules, and the *obras sociales* were free to define the services to be covered and the co-payments to be demanded of beneficiaries at the time of receiving care. Their financing source consisted of income-related contributions from employees and employers. The proportion contributed by each changed over the years, from 1% and 2% of salary by the employee and employer, respectively, to 3% and 6%, as established under Law 22.660.

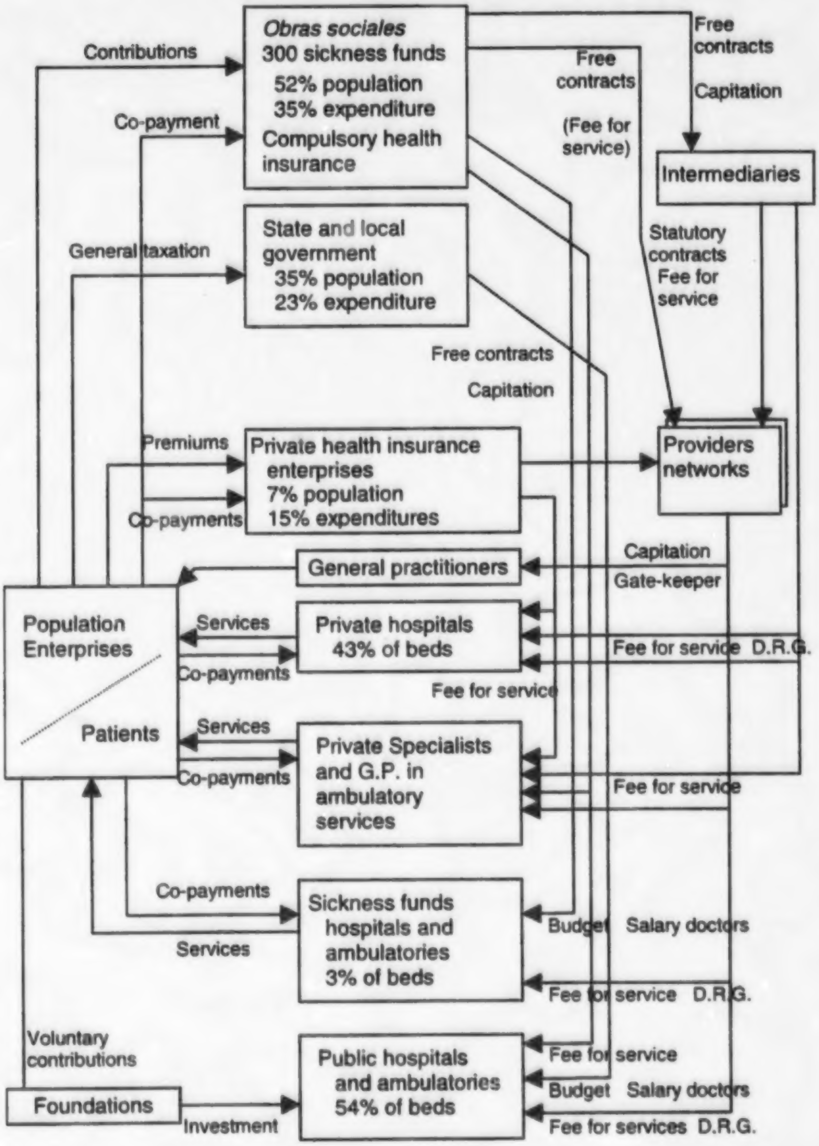
The combination of grouping beneficiaries by occupation and setting contributions proportional to wages made the financial capability of the *obras sociales* heavily dependent on existing employment and wage levels in each occupation. Insufficient coverage, poor service or excessive bureaucracy induced a small percentage of beneficiaries to procure supplementary coverage through private insurers. The range of premiums was very broad, as was the quality and scope of the services provided.

In the case of the public subsystem, it is not possible to speak of a relationship between the population and the institutions in charge of assigning resources and supplying services. The promotion of forms of "popular participation" underwent periods of ebb and flow, but never constituted a real possibility for intervention by the population in decision-making.

The emerging model

The current subsystems in the health services system (HSS) operate along the same general lines as those already analyzed for the period between 1960 and 1980. One notable difference, however, is the significant growth of the voluntary contract model, in the form of private insurance schemes, particularly those oriented toward the higher-income population. The other changes that support the hypothesis that a new model is now in place will be examined in greater detail with respect to the three subsystems. The two models are depicted schematically in Figures 1 and 2. As can be seen, the general structure of the two models is similar, but the relationships between payers and providers have undergone important modifications, as have the distribution of financial and material resources between subsystems, with the intermediary organizations growing in importance.

Figure 2. Argentine health services system presently in gestation.


Obras sociales
300 sickness funds
52% population
35% expenditure
Compulsory health insurance
Contributions
Co-payment
Free contracts
(Fee for service)
Free contracts
Capitation
Intermediaries
State and local government
35% population
23% expenditure
General taxation
Statutory contracts
Fee for service
Free contracts
Capitation
Private health insurance enterprises
7% population
15% expenditures
Premiums
Co-payments
Providers networks
General practitioners
Capitation
Gate-keeper
Population
Enterprises
Patients
Services
Co-payments
Private hospitals
43% of beds
Fee for service D.R.G.
Fee for service
Services
Co-payments
Private Specialists and G.P. in ambulatory services
Fee for service
Co-payments
Services
Sickness funds hospitals and ambulatories
3% of beds
Budget
Salary doctors
Fee for service D.R.G.
Voluntary contributions
Public hospitals and ambulatories
54% of beds
Fee for service
Budget
Salary doctors
Fee for services D.R.G.
Foundations
Investment

Relationship between third-party payers and providers

The most important changes in the *obras sociales* system have occurred in the relationship between third-party payers and providers, in particular in the use of incentives aimed at ensuring financial equilibrium. This section will begin by relating the changes that have occurred in the various instances involved and in the contractual agreements between payers and providers. Then, it will synthesize the modifications that have occurred in the form of payment for services under the new contractual regime.

Contracts between *obras sociales* and providers have ceased to be centred in the organizations representing the latter. Deregulation has affected the entire supply system by stimulating suppliers to abandon the protective umbrella formerly afforded by the corporations of providers. The financial crisis of the *obras sociales* prompted those providers able to secure a better position in a somewhat more open market to abandon corporate contracts. The new groups formed were Uniones Transitorias de Empresas (UTEs, temporary associations of enterprises) or providers' networks. These were associations of private hospitals, independent professionals, and, in some cases, public hospitals that agreed to contracting conditions with certain *obras sociales*. These contracts abandoned the traditional form of remuneration, the fee-for-service payment. Instead, they adopted per-capita remuneration and a form little used as yet, of lump-sum payments to diagnostic-related groups or "modules." In this way, the UTEs or provider networks periodically receive a lump sum that they have to manage and transform into fees for services provided to their beneficiaries.

This change in the method of payment has had considerable consequences for both payers and providers. The introduction of per-capita payment — a fixed sum per beneficiary covered by the financing entity — transferred the economic risk from the *obras sociales* to the provider networks. In this way, the *obras sociales* gained predictability in managing their budgets. Provider networks were obliged to control their members' production by developing mechanisms for limiting costs and services so as to assure the viability of the financial scheme for which they were now responsible. These new contracting methods also favoured the appearance in the market of contract management businesses: the Administradoras de Prestaciones (APs, services managers), equivalent to the managed care organizations in the United States. These possessed no facilities of their own, but rather acted as intermediaries between the *obras sociales* and the providers' networks, taking responsibility for managing resources put on the market by the *obras sociales* under the per-capita system. To this end, the APs contracted with one or more provider network and took charge of managing the services thus provided.

The institutions responsible for managing contracts had to discourage their members from over-provision of services or charging for practices not performed. It must also be noted that introduction of the per-capita method came about in a market with an oversupply of providers in relation to the capacity to pay. This required that either all providers in the system reduce their remuneration or that resources become concentrated in those services with the greater marketing or lobbying capability, forcing out part of the existing supply.

The new system, although still somewhat unstable, has so far produced better financial equilibrium. The instability is due to management organizations' difficulties in controlling their members in the presence of strong incentives to beat the system, especially on the part of those providers with better chances of accruing clientele.

The new method of operation is becoming the norm among *obras sociales* under the national jurisdiction and has also been adopted by the provincial *obras sociales* with numerous beneficiaries. The smaller ones, generally found in the poorer provinces with fewer resources at their disposal, have not introduced forms of payment permitting them to transfer the risk to the providers. They continue to record a considerable level of overcharging and over-provision; in some cases have excessive management costs; and control expenditure through the use of co-payments and barriers to access.

Also noteworthy is the private sector's strategy of investing in improved technology, which was expressed in an acceleration of the rate of capital formation from 1991 onward. The stability in prices achieved through the Convertibility Plan and the stimulation of competition through deregulation suggest an explanation for this tendency, which nevertheless seems contradictory in view of the oversupply of health services and the reduction in health spending. Some analysts think that opening up the economy allowed the country to bring its technological capacity close to that of more developed countries, and that investment in complex technology was a defensive strategy adopted by providers in the face of market saturation. The strategy of product differentiation took the form of acquiring of new equipment (Tafani, 1996).

Voluntary insurance schemes providing services under contract continued to pay for services provided by provider networks or their own institutions on a fee-for-service basis. Their viability was assured in part by the fact that they controlled greater resources per beneficiary than did the *obras sociales*.

In the integrated public subsystem, the main differences in the relationship between financing and provision of services came with decentralization, when the hospitals were allowed to function independently, as self-managed hospitals. This encouraged them to generate resources of their own, which they could use to improve their facilities or increase the remuneration to their personnel. In some jurisdictions, an attempt has been made to introduce prospective budgets based on expected demand.

Relationships between patients and providers

As noted earlier, the number of beneficiaries in the of compulsory contractual system (*obras sociales*) declined as a result of changes in the labour market, particularly, the reduction of salaried workers and the decline in the numbers of people employed in, for example, the metalworking, textiles, and railway sectors. Moreover, access to health care by the subsystem's beneficiaries was also affected during the years of financial crisis by frequent withdrawal of services by providers in response to delays in payment or failure to comply with debt cancellation agreements.

This situation has gradually been rectified since the contracting system was modified as described in the previous section. At present, except for partial and localized conflicts, only Programa de Atención Médica Integral (PAMI, comprehensive health care program) is still subject to reduction or cessation of services to beneficiaries. This *obra social*, dedicated to pensioners and retirees, is of great significance within the system because of the number of beneficiaries in its charge, the magnitude of resources per beneficiary and, consequently, the total amount of resources it pours into the system. However, for various reasons, it has not managed to put its affairs in order and is currently ungovernable and in need of refinancing.

An additional consequence of the new contracting method is that beneficiaries of other *obras sociales* have suffered a reduction in the broad choice of both independent professionals and hospitals that they enjoyed under the previous model. Because of the new relationships between payers and providers, the supply of professionals and services has been greatly reduced for each *obra social*, and beneficiaries can opt only for services from the provider network with which the financing entity has signed a contract. There has been no modification, however, in the right to enter the system at any level and choose freely between general practitioners or specialists, whether in independent practice or integrated into more complex institutions. Nor has there been any regulation of, or limits set to, prescribing by professionals. Expenditure control on pharmaceuticals and procedures is accomplished through cost sharing, as well as audits, in the case of the latter. The introduction of gatekeepers, with a view to rationalizing consumption and containing costs, has been minimal in the system as a whole.

It is very likely that the changes mentioned in contractual relationships between those who finance and those who provide services will have, as a secondary impact, the further stratification of the beneficiary population. This is because contract management has had to become more careful regarding expenditure, and incentives have ceased to encourage over-provision of services or over-charging. Instead they have begun to reward systems that can control consumption. Also, the abrupt fall in inflation now prevents liquidating debts between financing entities and providers through the simple expedient of delaying payment.

The provincial *obras sociales* have, for the most part, continued with the system of free choice and fee for service, despite evidence that this encourages over-provision. Policies for curbing expenditure are directed toward co-payments, which vary between 20% and 30% of the value of each practice, and applying bureaucratic hindrances to discourage consumption. The population covered by *medicina pre-paga* (private insurance systems) has access to a relatively sophisticated set of services that over the last few years have incorporated the latest technical advances in matters of diagnosis and treatment at levels that are probably far above the needs of the insured population.

One feature characterizing the evolution of supply in recent years has been the emergence of new forms of health care service, that is some services that were formerly dispensed through hospitals are now being supplied through other facilities. These include emergency services, patient transport, day surgery, ambulatory services, vaccination, and home care. These new organizational forms, the result of the incorporation of new technology in ambulatory care, are concentrated in the metropolitan area and in the larger cities. The greater stratification in the beneficiary population and the greater obstacles encountered by its weaker sectors in getting the health care that they demand, are also reflected in the growing number of *obras sociales* beneficiaries requiring care from the public subsystem.

The public subsystem has therefore seen an increase in the population it serves, as expressed in the number of consultations and discharges. Other changes to the public subsystem concern to the greater importance assigned to primary (first-level) care, ambulatory service and focused programs aimed at covering high-risk groups. In the case of primary care, the change is apparent in the increase in outpatient services already mentioned. Focused programs form a part of projects financed by the World Bank — the most important at the national level being the Programa Materno Infantil (PROMIN, maternal and child health program) — or originate in local or national initiatives managed at the local level. These would include AIDS programs or food aid for poor families.

Relationships between population and third-party payers

This relationship is being deeply modified by government decision and strongly resisted by the trade unions, the net beneficiaries of the existing system. If the government succeeds in imposing its authority, employees will no longer be forced to join the *obra social* representing their occupation and will instead be able to channel their contributions into the institution of their choice. This strategy, called deregulating the *obras sociales*, is strongly backed by the World Bank and currently being put into effect after a 2-year delay in being sanctioned by decree. In the first year, the beneficiary will be able to choose from between all the *obras sociales* dependent upon the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration). Support by the World Bank has been expressed in the form of a credit designed to regularize the financial situation of organizations wishing to be included in the program; to finance layoffs of redundant managerial staff; to obtain technical advice on updating information services; and to establish cost-control mechanisms.

The deregulating strategy is intended to promote competition in order to encourage efficiency in the management of resources by every *obra social*. Second, it is intended to stimulate mergers between *obras sociales* with few beneficiaries in order to reduce the number of institutions and increase the number of beneficiaries per institution, thereby obtaining an adequate risk pool. The main obstacle to rationalizing the existing system comes from the enormous disparities between *obras sociales* in terms of the amount of contributions per beneficiary. If the low-income population should move en mass to the *obras sociales* with higher per-capita resources, it is likely that this would lead to the collapse of the few institutions with balanced finances.

To address this problem, it has been resolved to limit the coverage that each *obra social* is obliged to provide to a "package" of services determined by the Programa Médico Obligatorio (PMO, compulsory medical package). The cost of the package is estimated at US $40 per month for each entitled beneficiary and attached family group, and ANSSAL guarantees that minimum contribution to all entitled beneficiaries in the system. Those wishing to attain a higher level of coverage, or to have smaller co-payments when they need health care, will make supplementary contributions. That is to say that, above a basic minimum of services established by the PMO, there will be different coverage plans based on a person's ability or inclination to pay. In this way, the model incorporates the individual's own assessment of risk, which it is supposed will facilitate more rational management of available resources.

The policy of rationalizing the financing of health coverage and eliminating the subsidization of one subsystem by another also applies to beneficiaries of *obras sociales* who seek care from public services. The establishment of self-managed hospitals that are empowered by decentralization to manage resources has, as one of its aims, to identify the insured population availing itself of public services, in order to recover the cost from the appropriate *obra social* or private insurance company.

The need to cut expenditure has led a majority of public institutions to solicit contributions (*bonos voluntarios*) from the uninsured population requesting care. On the heels of this practice has come a revival of the *cooperadoras* or *asociaciones de beneficencia* — updated names for charitable foundations — to take charge of managing such resources. For example, a hospital purchases and installs, on its own or with the help of private resources, an expensive piece of equipment such as computerized axial tomography. This equipment is then made available to other public institutions at a lower price than that current in the private sector. The foundation undertakes the management of the resources thus collected and directs the investment policies of the hospital applying the innovation. The future ability of private insurance companies to attract beneficiaries under schemes of compulsory social security contributions has put the need to regulate such foundations, which up to now have governed themselves through free enterprise, on the political agenda. Legislation is being discussed at the parliamentary level.

Health Service System Regulation

The structure of health services in Argentina has been characterized by a very weak presence of the state in the form of regulatory activity. According to the National Constitution of 1853, jurisdiction over health care activities belonged to provincial governments. However, as institutions representing the medical profession built in strength during the 1920s, the provinces gradually delegated various regulatory functions, such as the granting of licenses, the certification of specialists, the installation of private facilities, and, later, the supervision of private insurance organizations, to professional corporations. Medical schools flourished under the control of the academic professional sector, partly by virtue of university autonomy sanctioned by the reform process of 1918. Something similar happened in public health institutions under national, provincial, or municipal jurisdiction. Although regulation was in the hands of state officials or "technocrats," doctors predominated in decision-making, and in their role as state officials. They defended their supposedly superior knowledge as professionals in regulating aspects concerning setting standards, defining priorities, organizing services, and controlling their practices.

Relatively early, therefore, the medical profession achieved autonomy from the state with respect to regulating the training, licensing, specialization, and practice of its members, following the model prevailing in Anglo-Saxon countries. With the development of health and social security, the medical profession lost part of that autonomy, particularly in matters relating to working conditions and remuneration, because the financing institutions were under the control of the trade unions, with or without participation by state officials. At the same time, independent professionals and enterprises owning private hospitals set up their own associations. In the 1950s and 1960s, these professional associations, or corporations, developed a considerable ability to defend their professional interests. They controlled the contracting for the provision of services to beneficiaries of *obras sociales*, to the point where they formed an oligopoly.

In 1970, the state attempted to assume control of health and social security by extending coverage under the *obras sociales* to the entire population of employees. The professional associations were forced to accept arbitration from the Instituto Nacional de *Obras sociales* (INOS, national institute of *obras sociales*), in which the presence of the Confederación General del Trabajo (CGT, general labour confederation) carried decisive weight. Even then, the state presence continued to be weak, and negotiations between professional associations and trade unions centred chiefly on the regulation of professional fees and charges.

The professional associations applied all the negotiating skills that they had developed under the previous circumstances (contracting freedom) to the new institutionalized relationship with the *obras sociales*. Contract specification, terms of payment for services, and the procedures specified in the *Nomenclador Nacional de Prestaciones* (national nomenclature of medical fees for services), as well as their relative prices, were all established by professionals in their role as advisors to the professional associations. The profession also managed to play a fundamental social role by imposing principles such as freedom of patients to choose their doctors, the freedom of doctors in prescribing, the fee-for-service basis of payment, and the exclusive right of professional organizations to control the ethical, technical, and scientific aspects of their members' practices.

Thus, the regulatory model in effect between the 1960s and the 1980s featured the predominance of the medical profession at practically all levels of activity: in the development of standards for meeting the health needs of the population, in the organization of services of all kinds, in the training of medical and paramedical personnel; and in the definition of contracting methods, working conditions, and remuneration.

On the other hand, no direct regulation or control was applied to the specific work environment (consulting room, operatingroom, or hospital ward), in which the professional established a relationship with the patient in privacy. Decisions concerning the diagnosis of needs and the resources necessary to resolve them, the content of prescriptions, and folow up were likewise unregulated. Standards founded on particular scientific knowledge were assumed to have been incorporated by the professional during training and therefore excluded from supervision — not as an intrinsic professional right, but because it was believed to be the only guarantee of the efficacy of the therapeutic bond. Hence, it was not a question of the professional associations regulating and supervising their members' practices, but of each of those members applying particular judgments to complex situations in a personal and private relationship with the patient. It was supposed that the efficacy of such a relationship would be compromised by the intervention of a third party not authorized by the professional.

Another area likely to be subject to regulation and control in the future is that of the management of contracts at the macro level according to a standard-of-performance indicator that would provide information on the balance between needs, demand, and the production of services. This function has not been carried out at any of the levels where it might have been, mainly: the corporations representing supply in the planning of contracts; the *obras sociales* responsible for managing the resources in their charge; or even the state itself, as being responsible for the functioning of the health services system overall.

Thus, regulation of medical practice gradually weakened because of growing specialization and the rise of existing or potential situations of conflict in specific areas of activity. The literature usually differentiates between distinct and potentially conflicting fields of professional interest as follows: academics, services management, and professional practice. Divergent roles, occasionally fulfilled by the same professional, led progressively to the shaping of specific interests in, or approaches to, professional conditions and methods of application.

In the case of Argentina, that differentiation evolved gradually and in a relatively peaceful way as the services system grew and diversified. On the other hand, the struggle for control of social security contracting brought out potentially conflicting interests in the form of two powerful rival associations representing independent professionals and private hospitals, respectively. The rivalry between them had been relatively restrained during the years of financial stability, but became a struggle as resources dwindled. The struggle was not expressed as a conflict between associations, however, but became the daily preoccupation of individual practitioners as they attempted to avoid losing ground.

The scenario changed with the deregulation of supply. Our working hypothesis is precisely that the change in relationships within the health care system led to a change in the instances and methods of regulation. Centralized regulation disappeared with the reduction of the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration) in terms of function and political weight, and the elimination of the oligopoly over supply in the hands of the associations. The freedom in pricing and form of payment that characterized the new contracts deprived the *Nomenclador Nacional de Prestaciones* (national nomenclature of medical fees for services) of regulatory value, such that its list prices were no more than suggestions.

Because of contracting freedom, the most common means of regulating the system is generated by the play of the market, which existed but had little weight up until now. Payers and service providers freely negotiate capitation values and devise lists of professionals, services, and procedures covered by the contract. Admittedly, the result scarcely constitutes an open market because of the continued oligopsony (a market situation in which a few buyers control the demand from a large number of sellers) and of the limited number of providers' networks or Uniones Transitorias de Empresas (UTEs, temporary associations of enterprises) representing the supply in each locality. Nevertheless, there is complete freedom to sign or rescind such contracts. There is no existing entity superior to the contractors themselves to assume control of the signed agreements. In the face of failure or voluntary retreat on the part of the state, there has been no rise in the system of consumers associations or *obras sociales* beneficiaries capable of defending the public interest.

There has also been a weakening of professional regulation of the organization and management of services. Under the previous model, the professionals had to come to an agreement with the managers, but directors of institutions were sovereign in their own sphere of action to made decisions exclusively to generate benefits for the whole. This situation has now been transformed through risk contracts paid on the basis of capitation. Capitation means that a pre-established sum per beneficiary, per month, is paid to the provider organization. Payment is dispensed for actual services rendered according to pre-established rates on a fee-for-service or other basis. Thus the interests of each individual provider in maximizing production conflicts with the profitability of the organization as a whole, and managers must be vigilant to ensure that the services produced do not exceed the amount available for payment.

Transferring economic risk from financing institutions to service providers through per-capita payments leads to a new regulatory challenge that rests with the directors of the provider network or in the service management organizations. New managers arise who may or may not be health professionals and whose function is to defend the interests of the provider networks, partly to the detriment of its individual members. The new financing mechanism discourages over-provision or overcharging. Supply-side management becomes an indispensable instrument for guaranteeing the profitability of the whole, but clashes with the traditionally accepted autonomy of the professional in decisions related to the doctor-patient relationship.

Attempts to control the system ex-ante, through previous authorization of practices, have proved ineffective. Attempts to control it ex-post, through statistical techniques, do not always make it possible to identify individuals physicians responsible for deviating from the norm. Thus, renegade conduct endangers the permanence of the new model.

Discussion

To finalize this presentation, it is necessary to identify clearly the subsystem where the most important changes in the health service system have occurred, bringing about modifications in financing, regulation, organization, and provision of health care. It is equally important to distinguish these from those subsystems in which the changes have been quantitative (in terms of population covered), but insufficient to alter the institutional design. The public subsystem and the private voluntary insurance subsystem, which provide coverage to about 50% of the population, have not had any essential aspects of their function changed by the reform projects.

In the case of the private insurance system, this may be because its organizational methods are governed by the logic of deregulation and the freedom to contract that guided the reform policy. Nevertheless, the possibility that at some time in the future these institutions might draw beneficiaries away from the social security subsystem necessitated the approval of a regulatory framework aimed at preventing discriminatory practices, such as refusing coverage to people with pre-existing conditions or in specific risk groups. This regulating legislation has not yet been passed.

As to the public subsystem, the main reform measure applied was decentralization, from the national government to the provincial or municipal governments. There has also been some progress toward the implementation of self-managed hospitals, in particular in the matter of obtaining additional financing by billing the *obras sociales* for care provided to their beneficiaries.

The most ambitious proposals, however, have yet to be implemented: those aimed at separating financing and provision by establishing demand-subsidizing methods. In some jurisdictions, concern with costs is slow to sink in; the licensing and accreditation process has made no headway; and no instances are known of setting budgets on the basis of production, efficiency, or the epidemiological profiles of the covered population.

The subsystem that has undergone the most sweeping changes has been the social security or *obras sociales* subsystem. Even in this case, one must to differentiate between the changes that have occurred in the financing institutions and the changes affecting provision, especially those that have occurred in the relationship between them.

It may be useful to begin by considering the reforms that were proposed but not fully implemented, mainly, the decree concerning the deregulation of the *obras sociales*, which was blocked by opposition on the part of the Confederación General del Trabajo (CGT, general labour confederation). If that deregulation had been adequately implemented and generally supported, the form of risk-sharing would have changed. It would have been possible to concentrate contributions in the *obras sociales* with the most efficient performance and the formation of risk pools of adequate size. This was the main objective of the proposal, but it has so far only been partially implemented.

The reforms that have truly been accomplished are those related to contracting freedom between payers and providers. Their effect on the services system has been manifold, affecting money flows, methods of payment, the weight of management in the system, forms of access to health care, and the organization of the services network.

The changes introduced have brought about modifications in the relative weight of each of the recognized methods of regulation:

- Central regulation residing in the Administración Nacional del Seguro de Salud (ANSSAL, national health insurance administration) has disappeared because it functioned fundamentally as a negotiating forum between payers and provider corporations.
- State regulation has been weakened further because the state has not assumed the function of controlling the system nor of generating information regarding its operation, standards, or quality.

- The most important nucleus of regulation is located at the intermediate level, and is expressed through the guidelines regulating contracts between payers, intermediaries, and direct providers.
- Professional self-regulation is still in effect, with as much weight as before in shaping human resources policy, controlling licensing and specialization, and defining standards of practice. Nevertheless, the power of the profession has been weakened in its ability to organize and manage services, and the financial balance of the system has limited the profession's role as agent.

The analysis of the process of change does not make it possible to recognize a new organizational model functioning in a clearly defined way. On the contrary, we are faced with a very changeable scenario in which old actors and new try to consolidate their presence in the system by redefining the rules that govern their interactions. This results in a highly stratified scenario, both with regard to the population and its demand for services, and with regard to the appropriation of material and technical resources on the part of the providers. The present study does not make it possible to define excluded sectors, that is, those sectors with unsatisfied demands for care. On the contrary, the Argentine system continues to be characterized by the availability of relatively complex services to all population groups. The specific form in which each demand is resolved, however, may lead to exclusion from access to technical resources, which are unevenly distributed within the services system.

Chapter 4.

The Context and Process of Health Care Reform In Brazil

Lenaura Lobato and Luciene Burlandy

Introduction

This chapter will describe the social and historical factors that shaped the process of health care system reform in Brazil. It will also examine the social and economic context within which the reform took place; the principles on which the reform was based; the extent to which it was completed; and an evaluation of the present situation.

The ongoing process of health care reform in Brazil has at least two general aspects. First, the last two decades have seen profound changes in the country, as much in economic terms — the result of world-wide structural transformations — as in socio-political and cultural terms — the result of the consolidation of democracy. The health care sector has been influenced by all these changes, mainly because social policies in the country have historically been greatly affected by variations in politics and economics. Another general aspect of health care reform in Brazil is the ambitiousness of the reform proposals themselves, which aimed to modify a huge and complex system that had taken decades to build, and was consolidated during the most recent authoritarian period.

During the authoritarian regime that began in the 1960s, the political system and the production system were modified simultaneously, leading to a period of accelerated economic growth stimulated by external and internal borrowing on the part of the state. A highly specialized bureaucracy played a major role in this process both economically and politically, expanding its institutional apparatus, including that of the health sector. Strong centralization, particularly at the federal level, was combined with policies designed to strengthen the private sector and aimed at increasing economic growth. A remarkable broadening of health care services took place during this period.

The economic model adopted in the country from the 1950s on had initially been very dynamic, especially in the industrial sector, and indicated a strong capacity for growth. However, this vigour began to wane as early as the end of the 1960s, generating an economic crisis in the 1970s with a huge social impact, along with the progressive deterioration of the authoritarian political regime.

The economic and political steps taken to rectify the financial crisis affected the public sector most of all. The state absorbed the negative impacts of the external debt, while public finances took on the role of adjustment variable. One of the means of adjustment was to privatize state institutions (Dain 1986), allowing the private sector to maintain much of its profits despite the losing momentum of the internal economy.

This set of factors, on one hand, compromised the state's financial capacity, and, on the other hand, helped discredit the military regime, which had difficulty maintaining power. This prompted a long and complex transition to democracy that lasted through the 1980s and assumed a particular shape, known as "agreed democratic transition" (O'Donnel 1987), because it was conducted largely by the authoritarian government itself. While pressure from civil society, revitalization of organized social groups and increasing public dissatisfaction played a decisive role in accelerating the process, most of the rules were set by the military government. This resulted in a high degree of institutional continuity and allowed the same groups to remain in power.

It is in this context that proposals for a public, universal, and democratic health care system emerged. Social movements and civil society organizations rallied around these proposals, and some of them were adopted by the health bureaucracy.

Reform proposals increased, with a view to profoundly changing the health care system, while the conservative elite was still in power. This elite for a time had no alternative to dictatorship and so adopted not only democratization, but also the rescue of the so-called social debt, as its own project. This situation changed after the first elected government following the dictatorship took power. Supported by the conservatives, this new government was clearly identified with liberalism and privatization and opposed increasing investment in social programs. This orientation remained up to the present government, which has sought to incorporate global structural adjustment measures into the Brazilian economy. And yet, it was during the two last governments that reform of the health care system was implemented.

In such a context, the path to health care reform was not smooth, but characterized by many disruptions. Nevertheless, considerable changes have been made in the health care system and social policy in general. For the first time, universal social policies have been adopted. Substantial changes in the institutional structure are evident in financing alternatives, the involvement of various levels of government, the introduction of innovative forms of management, and in social participation. Nevertheless, the system still suffers from low levels of financing and investment; poor quality services; and a limited ability to solve problems. Today, a large segment of the population uses private health care services, which have increased and diversified to the point that their revenue nearly equals expenditure on the public health sector, although they serve only one-quarter of the population.

Even with all these difficulties, it is impossible to explain the constraints on health care reform as solely the consequence of structural adjustment measures, as seems to be the case in various other Latin American countries. In fact, in contrast with most of these countries, the Brazilian government had no concrete proposals to include health care reform in the structural adjustment strategy. The reason that reform did not entirely follow the structural adjustment strategy may be explained in two ways. First, the momentum for reform, although no longer expressed through broad social movements as in the 1980s, has expanded significantly and been expressed principally through government institutions. For this reason, proposals aimed at altering the process underway would have a high political cost.

Second, there are particular characteristics to adjustment strategies in Brazil that are fundamentally different from adjustment strategies in other countries in the region and much more resistant to the orthodox stabilization process. Fiori (1995, p. 157) emphasizes two factors to explain this resistance. First, the existence of an "industrial fabric, an importing dynamism and a commercial diversification unparalleled in the continent," that rejects the Argentine approach of specialization as a way of gaining advantage in the international sphere. Fiori's other point (1995, p. 158) is that Brazilian industry is not complementary to any particular commercial partner and, therefore, discourages economic restructuring aimed at commercial integration, as in the Mexican case. In other words, it is not the weakness but the dynamism of the economy that prevents it from taking over the adjustment process in a more radical way. Having completed a process of heavy industrialization, the Brazilian economy does not passively accept changes neither in the international scenario nor position itself exclusively through the export sector.

Although the restructured economy has not clearly defined the role of social and health policies, it has at least presented an alternative to the reform process: "non-politics." This means the total absence of a clear strategy for the sector on the part of the government.

The following description of the reform process describes the context and analyzes the limits imposed on the Brazilian health care system.

Background Influences

Until the 1960s, health care services in Brazil were organized according to three subsystems, represented by social security, the Ministry of Health and the voluntary private sector. Social security was consolidated from the 1930s on, when the state began to participate in the financing of public and private companies' social security benefits, one of which was to provide health care to workers and their dependants. Social security institutions, then called Institutos de Aposentadorias e Pensões (IAPs, retirement and pension institutes), were organized according to professional categories and according to a classic insurance model: in other words, that benefits and assistance depended on the ability of the category of employee in question to contribute. Services could be provided through the private networks, as was the case for the richest institutes, or through contracts with the private sector. Social security became the dominant system for providing health care services in the country. As a consequence, health care followed a stratified model of social rights, expressed in terms of different levels of access by the various IAPs and the exclusion of segments of the population not participating in the formal labour market (Oliveira and Fleury Teixeira 1989).

The Ministry of Health, organized in a parallel structure, was responsible for preventive care. It retained a preventive focus (vaccination campaigns, sanitation, and so forth) until the end of the 1950s, when it was split into multiple services and departments operating in and uncoordinated manner. In terms of medical care, the Ministry was responsible only for the creation and maintenance of chronic care facilities.

The third subsystem, the private sector, was independent of the main subsystems and limited to services provided by autonomous physicians through direct payment.

The Social Security Organization Law, passed in 1960, standardized the benefits provided by the different IAPs. However, they were not yet unified and remained as isolated structures, serving their clients separately. The Law focused more on standardizing medical services, which were handled cautiously in the various decrees governing the operations of the institutes.

From the mid-1960s on, particularly after the start of the authoritarian regime in 1964, Brazil underwent a series of transformations to meet new industrialization and economic development aims. Government management became increasingly interventionist. Social policies, particularly health policies, were used to help legitimize the regime as well as stimulate the private sector.

It was in this context that social policies, particularly in the health sector, were made increasingly universal as the state took on more responsibility for the provision of services (Draibe et al. 1990).

In keeping with this trend, the organization based on the IAPs was unified into a single institution, the Instituto Nacional de Previdência Social (INPS, national institute of social security) under Decree 72 (21 November 1966). Social security coverage was extended, but remained restricted to specific professional categories in the formal market, thus keeping the clientele segmented. Rural workers, people employed in the informal sector, and the self-employed remained excluded.

The changes contributed to the creation of a specific model of health care in the 1970s, with basic characteristics that would become the principal targets of health reform. Among these characteristics were centralization; the dichotomy of institutions within the health care system; the growth in coverage through private provision of health care; incomplete coverage; and regressive financing.

Centralization

The unification of the social security structure consolidated resources and power under the central government, reducing the influence of state and local governments in planning and management.

Dichotomy of institutions within the health care system

The public health sector was structurally divided into two ministries with separate powers, clienteles, and operating methods.

- The Ministry of Health, established in the 1950s, was responsible for developing and coordinating national health policy; for public health and preventive medicine; for a network of hospitals for treating chronic disease; and for a basic network of health care services for those in the poorest localities.
- The Ministry of Social Security and Social Assistance, established in the 1970s by Law 6.025/74, was responsible for providing medical care to workers insured by social security.

In the 1970s, the institutional dichotomy was formalized by the creation of the Sistema Nacional de Previdência e Assistência Social (SINPAS, national system of social security and social assistance), within which different institutions were created, each responsible for a specific area of social benefits. Medical care became the responsibility of the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security). This new institution was an answer to the progressive growth of health care within social security that necessitated its separation from long-term benefits. Thus, INAMPS achieved significant political and financial power (Oliveira and Fleury Teixeira 1989), while the public health system became even weaker within the health sector as a whole.

Medical services were provided by both the public and the private sector. They were provided by the public sector through hospitals, health centres and primary-care units pertaining to the three levels of government, federal, state, and municipal. Private service providers were classified as follows:

- independent professionals or health services contracted by individuals or companies and financed by the private sector itself; and
- private sector contracts — profit and nonprofit units that provided services to the public sector under contract to the federal government

The relationship between the public and private sectors was restricted almost exclusively to services contracting, based on fee-for-service payment, with no control over the kind of medical care provided. Thus, medical care was characterized by high-cost, specialized, curative, and hospital-based treatment. The absence of policies based on the actual epidemiological profile and health needs of the population meant that services concentrated in the more profitable regions, causing an imbalance in supply.

This distorted health care model expanded through the mobilization of a growing volume of resources within the Ministry of Social Security and Social Assistance. This Ministry had the second largest budget in the country, only surpassed by the federal budget itself. Public health and primary care were not similarly privileged, however, enduring a progressive decline in investment due to reduced financing from the Ministry of Health.

Growth in coverage through private provision of health services

From the 1970s on, social security coverage was extended to workers who previously had none, but benefits continued to be linked to contributions. In addition, emergency care was expanded to cover the whole population, independent of an individual's affiliation with social security. This provoked an unprecedented increase in the demand for services.

The Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security), contracted more and more often with third parties to care for the increasing clientele. This gave the private sector a progressively more important role in service provision. As a result, the publicly owned network shrank and deteriorated. By 1976, for example, only 27% of all hospital beds were public, while 73% belonged to the private sector.

This quick and progressive extension of coverage enabled the military government to accomplish its goal of legitimizing the authoritarian regime and, at the same time, stimulate and strengthen the private sector. The latter was accomplished by:

- subsidizing debts to build hospital units with the guarantee of future contracts from INAMPS;
- subsidizing medium and large companies to take responsibility for the health care of their employees; and
- stimulating private hospitals to provide services to social welfare insurers, on a fee-for-service basis. This type of payment, known to stimulate the use of services, also led to widespread fraud due to the total absence of inspection.

Another historical tendency was reinforced when private-sector consolidation took place, not as the result of market economics and competition, but encouraged through subsidies and political guarantees conferred by the state. But although such public-private partnerships were responsible for the commercialization of medical care, we cannot discount their significance in expanding access to services. Therefore, the process was not based exclusively on market logic but also on the growing importance of health in the public agenda (Costa 1996).

Regressive financing

Social security funding was not supported by the fiscal budget, but by compulsory payroll deductions from workers and companies. Thus, the resources in this budget were extremely dependent on cyclical variations in the economy, particularly when recessions affected employees and salary levels.

The progressive extension of coverage carried out during the 1970s was not followed by a change in funding. The resources collected by the Ministry of Social Security and Social Assistance were expected to cover not only retirements and pensions, which resisted cuts because their amounts were predetermined, but also medical care, which did not require a specific budget. Thus, medical-care expenses incurred in hospitals were significantly reduced during recessions, as observed during the 1980s. The model was based on expansion, but the contributions were based on payroll, and tended to decrease.

In summary, a combination of factors culminated in what was called the social security crisis of the1980s. These factors included the proliferation of expensive medical care without a corresponding change in the method of financing; a method of paying the private sector that stimulated an increase in expensive specialized procedures, as well as fraud; difficulty in controlling finances because of the disorganized structure of the system; deterioration in the quality of services; and a national economic crisis allied to a broader crisis of international scope.

The answer to the crisis within the Ministry of Social Security and Social Assistance was simultaneously political and technical. A special council was established, having as one of its targets to propose strategies to deal with the crisis and to develop a framework to reorient health care within social security. The council was composed of government representatives, employers, and employees' associations. Because of this mixed composition (state and civil society), it constituted an important arena for projects that involved different social actors in the health sector.

The plan consolidated principles and updated proposals already championed by different social actors, either in the bureaucracy or in civil society. The strategies included those developed by technicians in the social security bureaucracy to rationalize expenses, and those proposed by civil society aimed at reorganizing the health care model and democratizing the health care system. The latter were adopted by the former with the support of the health professionals, who were better able to influence the state bureaucracy.

A number of financial and management measures were adopted. Criteria were defined for allowing the private sector to operate in the name of the government. Mechanisms were created to decentralize planning; budgets were integrated between the various levels of government. Social participation was to be encouraged. And, central government resources were to be transferred to the states and municipalities to restore their health units.

One of the core objectives of these strategies was the progressive transfer of health care to the states and, further, to the municipalities. Thus, the federal social security health units, which were previously responsible for providing services, had their duties redefined. They were now responsible for planning and co-financing. Control remained at the federal level, however, because it was the main payer.

The transfer of resources to the states and municipalities were based on the accomplishment of certain goals. But this did not stimulate independence at the state and municipal levels, however, because the transfers were not based on health needs but rather on services provided. Thus, the principles governing the private sector were extended to the public sector.

One of initiatives in the area of service provision and organization was to reactivate the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security)'s own hospitals. In addition, various attempts were made to make services more efficient by applying updated principles for structuring health care, such as integrating preventive and curative care, as well as different levels of care, within the existing capacity of the various regions.

These principles had already been applied in some experimental projects developed in the 1970s by various technical groups critical of the existing health care model. Based on proposals such as that for community medicine, these projects featured a reversal of the trend toward specialized curative health care and extended the decentralization of primary care delivery. This kind of project had not been successful, due to opposition from the INAMPS bureaucracy and the private sector, who had no interest in reversing the hospital-centred model.

Although these proposals were not entirely implemented, new primary health care units were installed. Their inclusion in the reorientation of the health care system strengthened various actors within the government bureaucracy, who would be important in the reform process.

The set of measures adopted during the 1980s reflected different projects involved in health system reorganization. These projects sometimes complemented and sometimes contradicted each other, depending on the positions of the actors involved. Thus, although the main purpose of reorganization was to control expenses, the measures were accompanied by a strong democratizing component. In part, this was because of political action by the people who would shape the social movement that was fundamental to the reform process, known as the Health Movement. Composed of intellectuals, health professionals, and left-wing militants from the opposition parties, the Health Movement identified democratization as central to the creation of an effective health care system and, in turn, attributed all the problems related to the health care services to the authoritarian regime.

With the decline of the authoritarian regime, democracy was reborn as the ideal for restructuring Brazilian society. A series of social demands had accumulated during the authoritarian period, among them demands for health care. The crisis in the health care system resulted in increased criticism of the model in force and renewed the proposal of alternatives.

The Health Movement strategically associated the demand for health care services with the demand for a democratic regime. The main principles of the Health Movement were that health is a right of all citizens, to be provided by the state through a universal health system based on integrity and equity in health care (Barros 1996). The effectiveness of the Movement required the construction of a political strategy that encouraged civil-society organizations to demand the universal right to health as an obligation of the state. The Health Movement also called for reform of the state bureaucracy and institutions.

It was thus on the issue of health system reorientation that the strategy of the Health Movement coincided with the rationalizing proposals of the social security bureaucracy, making health institutions the focus of health care reform.

The proposed reform was based on the following principles:

- restructuring financing mechanisms to broaden the support base beyond the payroll;
- reversing the process of privatization and establishing ways for the public sector to control the private sector;
- giving greater decision-making and financing autonomy to the states and municipalities; and
- introducing the participation of social organizations in formulating and implementing health policies.

The Reform Process

The 1980s was a period of intense discussion concerning health demands and health care policies. The policies adopted during those years to overcome the crisis in social security, as well as the broad social and political demand for sanitary reform (health reform), can be understood as part of the process of health care reform. However, it was only in 1986 at the 8th Conferência Nacional de Saúde (CNS, national health conference) — one of a series of official forums regularly called by the Ministry of Health to determine policy guidelines — that the reform became a policy in the strictest sense of the word.

The 8th CNS brought together not only broad sectors of civil society and representatives of the most important institutions in the sector, but also professional groups and political parties. The conference differed from previous ones in its participatory nature. It became a milestone in the reform process because its most important principles were enshrined in a national document. Its proposals would later be brought by the Health Movement to the Constituent National Assembly during the elaboration of the Constitution adopted in 1988.

The final report from the 8th CNS defines health from a comprehensive perspective encompassing many aspects, such as quality of life, leisure, sanitation, transport, work, etc., meaning that the changes to the health system should go beyond the limits of an administrative reform. The report concluded that health care should be administered by a single body, the Ministry of Health. Thus, it would no longer remain under the authority of the Ministry of Social Security and Social Assistance, which would become responsible for long-term benefits only.

An important step in the reform process was the creation of the Sistema Unificado e Descentralizado de Saúde (SUDS, unified and decentralized health system). As set out in 1987 by the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security), the aim of the unified decentralized health system was to carry out the transfer of health units and human resources from the Federal Government to the state governments according to a set of conditions. The Federal Government also delegated the appropriate responsibility and sufficient means to the states and municipalities to ease the transition to their new role in health services provision.

The reform of the health system was legally defined in the 1988 Constitution. It was called the "Citizens' Constitution" because it introduced significant improvements in terms of social rights. It defined health as an obligation of the state and imposed radical changes on the health sector, formalizing the main aspects outlined in the 8th CNS. The guiding principles of the health care reform were as follows.

- **Health as a right of citizenship**. All Brazilian citizens acquired the right to health care provided by the state, thereby characterizing health as an activity of public relevance.
- **Equal access**. All citizens should have equal access to health services, with no discrimination of any kind.
- **Health as a component of social welfare**. The health sector had to be integrated with the social welfare system, defined as an "an integrated set of actions provided by the state and society aimed at fulfilling rights related to health, social assistance and welfare" (Federal Constitution 1988, article 194). The connection of this statement with the financing plan led to the creation of a single integrated budget — the Social Welfare Budget — which gave each sector autonomy of management and resources, and guaranteed 30% of the budget for health on a temporary basis until rules and regulations had been set. These resources came from various sources: tax collection; social contributions, mainly by companies, to finance social activities; and contributions from employees and employers based on a percentage of the payroll.
- **A single administration for the public system**. One principle of health care reform concerned the creation of a single system to aggregate all

health services provided by federal, state, and municipal public institutions through direct and indirect administration, as well as foundations supported by public authority. The private sector was also allowed to become part of the system under contract; however, the public authorities retained the power to rule, control, and inspect the services provided. The Ministry of Health was responsible for monitoring and directing all activities related to health, including medical care, which was no longer under the control of social security.

- **Integrated and hierarchical health care**. The unified system had to be organized to provide integrated care by giving priority to preventive procedures without jeopardizing care at other levels. Therefore, promotional, preventive, and curative activities had to be based on the epidemiological profile of the population. Provision of services had to be arranged with respect to the health care hierarchy and had to provide people with universal access to all levels of care. The hierarchy had to operate on referral and counter-referral mechanisms, from the least-complex level of care to the most, ensuring continuity of care through the primary caregiver.
- **Social control and social participation**. The system had to be governed according to democratic criteria, and the participation of civil society in its decisions was of paramount importance. For this reason, it was proposed to create health councils at the federal, state, and municipal levels, to increase democratic participation in developing and implementing health policies. The health councils were to comprise representatives of the three constituencies involved: users, professionals, and managers. Health conferences, to be held at the national, state, and municipal levels on a regular basis, were also intended to stimulate and guarantee social participation. Various collegial institutions were to take over functions previously the exclusive domain of executive power, such as determining resource allocation, inspection, and regulation (Fleury 1994a).
- **Decentralization and regionalism**. Decentralization was a fundamental factor in health system reform because it led to a redistribution of the responsibilities between levels of government. Provision of health services had to become the responsibility of municipal governments, aided financially by the federal government and the states. However, all services had to operate within a unified system, because it could not be expected that all levels of services could be provided at the municipal level (Santos 1997). The need for a hierarchical and regional system led to the creation

of management forums at the various government levels, and to the strengthening of the role of municipal managers, who became relevant actors in the new system.

The introduction of these principles was preceded by extensive political debate. Even before the constitutional process, the National Congress was already considered an important centre for public debate and for developing alternative health policies, mainly through the deputies' Chamber of Health Commission. The period of debate that led to the development of the new Constitution was described as an exceptional opportunity for various actors to exercise political pressure by lobbying for the inclusion of their proposals.

The 8th CNS had already highlighted the different and sometimes contradictory concepts of reform held by the main actors involved in the process of reforming the health sector. The absence of important representatives from the private sector was a clear demonstration of their opposition to the resolutions of the Conference. At that time, the Health Movement still supported the thesis that all health services should be provided by the state, but found strong resistance from the medical association and even from the proponents of health system reorganization. Following the conference, these actors became more prominent in the political arena, especially in National Congress. Positions in the dispute ranged from the most private to the most public orientation.

In general, three major groups of actors could be identified:

- unions, professional associations, federal councils, and organizations linked to the Health Movement, which supported the reform project as defined at the 8th CNS, that is, a public and democratic system;
- private sector associations that had as a common objective resistance to any government control, but were distinct in terms of the interests of their particular subsystem. The contracted private sector wanted to continue providing services financed by the state, but with no technical and administrative interference, and also wished to increase its share of public income. In contrast, the voluntary private insurance sector, already significant at that time, wanted total independence from the state; and
- representatives of the health and social security bureaucracies who wanted to keep control of medical care (Neto 1997).

The principles defined in the Constitution — the guidelines for the new health care system — acknowledge that various actors and interests are involved and are expressly vague on non-consensual issues, leaving them to be defined later by specific regulation.

The Reform Implementation

The legal components of the Brazilian health care reform guarantees the state's right to regulate, inspect, and control the health system. The legal framework ruling the Sistema Único de Saúde (SUS, unified health system) is composed of the Health Organization Law (Laws 8.080/90 and 8.142/90), the federal Constitution, the state constitutions (1989), and the municipal organization laws (1990). Operational strategies for the system are outlined in the Normas Operacional Básicas (NOBs, basic operational norms) published by the Ministry of Health in 1991, 1992, 1993, and 1996.

The Health Organization Law (Laws 8.080/90 and 8.142/90) governs such items as: conditions for health promotion, protection, and cure; powers and resources of each level of government; and basic mechanisms for managing the system, including community participation through health councils and conferences. The two laws are complementary, as the second law (8.142/90) was passed after the first was vetoed by then-president, Fernando Collor.

Since the Organization Law went into effect, the administration of the SUS has reflected all the conflicts of interest and perpetuated all the ambiguities within the system. One of these concerns the difficulty of defining the roles and responsibilities of the federal, state, and municipal governments with respect to the SUS. The Organization Law 8.142/1990 governs the transfer of resources from the federal government, but remains silent on the responsibilities related to the different agencies and levels of government, leading to duplication of some activities and gaps in others.

The most important issue, however, is that the sphere of action of the SUS legislation is almost entirely restricted to the public sector. Although the government has the right to inspect and monitor both public and private sectors, neither the 1988 Constitution nor the Health Organization Law include any provision for private sector regulation.

The years since the formal reform legislation was passed have, therefore, been marked by conflicts over certain points, with the result that implementation of the system has been slow and uneven across the country.

Municipalities differ significantly in their ability to handle health services and in their relations with other levels of government. This has led to the development of various processes for transferring health services to municipalities across the country. The dynamics of transfer are also influenced by broader political and social differences, such as conflicts between public and private interests.

It is, therefore, possible to identify three broad politico-governmental periods since the beginning of the implementation of the reform settlement:

- 1990-92, in the context of the first government elected after the military dictatorship and immediately after legal recognition of SUS in the Constitution;
- 1993-95, when government restructuring caused by presidential impeachment took place; and
- 1995 on, following the election of the present president.

As already explained, the initial stage was developed during the first elected government after the military dictatorship. The new government adopted an economic policy based on structural adjustment, reduced state intervention, and enforced privatization. While the sanitary reform clearly advocated government control, the government in power favoured a liberal-privatizing approach. In the health sector, as in the field of social policy as a whole, resources were immediately reduced.

Reduced financing further weakened the network of hospitals. To make ends meet, the average fee for service was reduced. The private sector was the major health service provider, with most of its financing coming from SUS contracts. Erosion of profits led many private companies to terminate contracts for high-cost procedures. Only those companies that had not been able to modernize their operations remained linked to the public sector, significantly affecting the quality of services. Other companies preferred to keep their contracts but not fulfill them, in an informal breach of contract (Mendes 1993).

Such an unfavourable political environment adversely affected the constitutional principles governing the Health Organization Law. As a result, various articles concerning financing, decentralization, and community participation were vetoed. The automatic transfer of federal resources to municipalities was vetoed as well. This helped slow down the decentralization process.

At this stage, the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security) remained responsible for medical care. The technical bureaucracy saw decentralization as a weakening of its political and financial power. Control over financing medical services had for many years guided important political relationships in the authoritarian regime. INAMPS maintained offices in all the states, through which demands were negotiated. Representatives frequently acted as key persons in the local political arena. INAMPS was thus an important mechanism in looking after central government interests in the states and municipalities. The contracted private sector also preferred that INAMPS be maintained because of its political proximity to the bureaucracy. However, sole command was a key point in the creation of SUS, which meant that the health system was heading for a power struggle. It was only in 1993, after presidential impeachment, that INAMPS was abolished and the strategies outlined in the reform began gradually to be implemented.

The Normas Operacional Básicas (NOBs, basic operational norms) provided the Ministry of Health with a gradual, flexible process for allowing states and municipalities to join SUS according to the management provisions most convenient for them.

The powers of the different levels of government were defined as follows:

- The federal government was responsible for developing national policies; controlling national regulation through SUS; providing technical and financial assistance to states and municipalities; and regulating public-private relations and private sector activity.
- The states controlled the regional network and hierarchy within the state, as well as supervised and provided technical and financial support to municipalities.
- The municipalities were responsible for providing health services and health planning.

To manage the system, bipartisan and a tripartisan management commissions were created. The first were composed of state and municipal representatives, and the second of federal, state, and municipal representatives. As negotiating forums, they had the power to follow up on the decentralization process and to assess municipal conditions in order to fit each into the most appropriate level of management autonomy.

The 1993 NOB classified the degree to which a municipality had assumed responsibility for health service provision (including contracting with and supervision of the private sector) as incipient, partial, and semi-complete. At the maximum level of autonomy (semi-complete), the municipality no longer received resources from the federal government that were linked to providing services, but did receive a lump sum, based on historical expenses, to support health care (Barros 1996).

In addition to the management commissions, the Federal National Health Council and state and municipal health councils act as central forums in the process of health policy development at the various levels of government. The councils are legal entities comprising representatives of government and SUS users, as well as representatives of various civil society associations. They operate differently in the various municipalities and states, and join the inter-managing commissions to a greater or lesser degree, depending on the political relationships they establish with state and municipal governments. In other words, although they have the legal responsibility for heading the system in the name of the executive power, their effectiveness varies from state to state and municipality to municipality in accordance with the political relationships between the councils and the executive power.

At present, the Federal National Health Council is the most active council and assumes an important role in analyzing and discussing projects presented by the federal executive power. Its actions have been marked by strong technical support and an excessive preoccupation with regulation. However, there is tension between the Council and the executive power caused by the presence of diverse actors. Although all measures are supposed to be presented to Council, the executive power does not always respect this law — whether it does or not depends on the interests involved.

In addition to these institutions, the roles of the Conselho Nacional de Secretários Estaduais de Saúde (CONASS, national council of the state health secretariats) and the Conselho Nacional de Secretários Municipais de Saúde (CONASEMS, national council of municipal health secretariats) have been strengthened. These councils are civil entities with public status that participate in both the Federal National Health Council and the inter-management commissions.

The involvement of all these institutions in planning and managing the system has been recognized as an important instrument of democratization and one of the sanitary reform's most radical changes (Castro 1992).

Although the problem of financial restrictions remained from 1993 to 1995, it was the 1993 NOB that gave the reform its most important stimulus. Many municipalities achieved semi-complete status, thus increasing their degree of municipal autonomy within the health system. Under the decentralized system of operation, many municipalities started to administer services according to the needs of their populations. Many innovative arrangements were introduced, such as family doctors and health agents. Some municipalities invested in primary care and health centres, trying to reduce the use of hospitals for primary care. On the other hand, better control of services provided by the private sector were developed. Other management measures were applied to improve the delivery of health care, such as contracting out ancillary services such as cleaning, nutrition, etc., encouraging independently managed hospitals, and contracting with medical cooperatives for care.

From 1995 on, the health system suffered deeply from the withdrawal of financial resources. Because of this, one of the main activities of the Ministry of Health centred on negotiating a fixed amount of resources for the health system, because since 1993 the INPS had suspended the transfer of resources determined by the Constitution. A special tax on banking transactions was finally approved in 1996. This amount was to supplement the health budget by about 4 billion Brazilian reals (in 1997, R$ 1.00 (Brazilian real) = US$ 1.15). However, in 1997, the first year of the new contribution, the Ministry of the Treasury held back about R$ 1.7 billion instead of transferring it to the Ministry of Health.

On the side of the federal government, the only important measure adopted since then has been the new operational standard by the Ministry of Health, which was published in 1996 but only came into effect in December 1997. This NOB made progress in terms of regulating management at the municipal level. The municipalities are now able to apply for one of only two levels of management autonomy, the one taking responsibility for all primary care and the other for the whole municipal health services system. Municipalities not able to do one or the other of these two possibilities will remain SUS service providers under the control of the state.

This NOB reinforces the function of the inter-management commission as a key instrument of integrating and harmonizing the roles performed by municipal, state, and federal subsystems. It also governs the shared provision of services, by means of inter-municipal consortiums, which draw up planning and budgeting agreements.

An underlying issue concerns the definition of a health care model based on family health and aimed at strengthening basic care, as well as the relationship between the health team and the community. In this sense, the model reinforces the integration between individual medical care and the epidemiological approach. As part of the strategy for reorganizing the health care model, a regular and automatic transfer of resources from the National Health Fund to state and municipal funds was introduced through NOB in 1996 to fund primary care. The amount can be increased if the municipality develops community-based programs for family health or community health agents.

A consensus on the general principles of sanitary reform is growing in all the decision-making institutions created since the Constitution. However, improvement in health management has not overcome the lack of investment nor the lack of a clear policy in the system. There are still intense conflicts concerning the allocation of financial resources between the various levels of government. The disagreement between different interest groups remains within the health sector, mainly between defenders of a tendency toward privatization and those who advocate government control.

The role of the private sector under SUS had been a major source of conflict during the drafting of the Constitution and still flourishes. Prepaid and private health insurance plans have been stimulated first by the reduction in public services and then by public subsidies in the form of income tax deductions on the part of companies and consumers. However, high prices caused increasing complaints against the services provided under these plans, compelling Congress to reopen the debate. After months of discussion and negotiation, a proposal to regulate the sector was approved. It is far from what the critics of private services wanted; however, there seems to be a consensus within the health sector that considerable improvements were made and that this law is better than nothing.

From now on, companies are obliged to offer at least three basic plans. The most complete (and most expensive) covers all the diseases registered by the World Heath Organization (WHO), and includes hospital stays and office visits. However, it does not cover many complex procedures, such as transplants, and does not include drugs. A patient with AIDS (acquired immune deficiency syndrome), for example, will now be covered by these plans, but the drugs will still be the responsibility of the public system. Two very important aspects of the new legislation are the end of the limit on hospital stays and the prohibition against raising prices for beneficiaries over 60 years of age, as long as they have been with the plan more than 10 years.

Many complaints had resulted from companies refusing to cover patients with "pre-existing" conditions. Now, companies are at least obliged to treat the patient, and the onus is on them (and not the patient) to prove the pre-existence of the disease. On the other hand, if the company can prove that the patient already had the disease and knew it when the contract was signed, the patient could be obliged to refund the company. Workers entitled to health care through their employers have the right to maintain the insurance for a period in case of unemployment or retirement, as long as they pay the employer's portion.

Two aspects of this regulation are especially important for a better functioning of the health system as a whole. First, SUS is allowed to charge private companies for services rendered to their beneficiaries in a public health unit. Second, the Ministry of Health has created a subordinate council to monitor the activities of the voluntary private sector. The creation of an organization independent of SUS may be understood as the definitive separation of the public and private sectors. Moreover, besides the immediate improvement in the quality of services available to the population, it leads to the possibility of developing mechanisms of negotiation and commitment to long-term policies.

Evaluation

One of the basic tenets of health care reform was the definition of a client profile based on citizenship, as set out in the Constitution, which not only emphasized universal access to health care but also strengthened the public nature of health care, i.e., that it is a responsibility of the state (Costa 1996).

In addition, decentralizing and strengthening municipal governments brought significant benefits to the system. One cannot say that the decentralization process in itself guaranteed better health care. This was, among other reasons, because sometimes local governments passed on even more intensively the distortions that had occurred at the federal level, such as patronage. However, the increasing participation of municipalities in the provision of health services — which meant, in some cases, investing in localities that were not previously priorities — reduced regional inequalities in terms of beds and medical consultations. As well, the number of outpatient institutions is expected to have significantly increased with the improvement in the network of municipal services (Barros 1996).

The inter-municipal consortiums — local government partnerships for providing health services — are making it possible reopen institutions that had been closed and hire specialized professionals, giving particular localities access to new kinds of care (Barros 1996).

Decentralization has not only generated the transfer of resources, but also of managerial skills. In the longer term, this stronger technical ability will translate into better quality service (Fleury 1994a).

However, critical points remain concerning the relationship and powers between the different levels of government. To a large extent, this is because there are no automatic financial transfers to states and municipalities. The use of federal resources by states and municipalities is subject to technical assessment by the federal government, which decides the amount to be transferred, while maintaining control of the process. This means that the transfer of power may sometimes not be proportional to the resources.

Because they are incorporated under a single legal structure, SUS has considerable problems coordinating services linked to institutions at different hierarchical levels, which traditionally were very different in terms of the salaries and services that they provided. There are contradictions between the traditional administrative, financial, and organizational structures and the principles of decentralization, integrity, and social participation.

Municipalities need the necessary structure to develop their new role as health system managers. As well, planning activities, which involve developing actions, scheduling, following up, monitoring, and assessing, have not been effectively developed by the various levels of government. Added to this, low salaries and poor working conditions have reduced the number and quality of staff, which threatens the smooth operation of these institutions (Barros 1996).

Another negative aspect of centralization has been perpetuated. As long as the federal government transfers resources to states and municipalities through agreements that are based on production levels of physicians and hospitals, provision of services will be used to maximize resources. The few financial incentives provided for preventive programs by the national government have done little to contest this logic.

Financing is another issue with enormous impact on health reform implementation. The establishment of SUS occurred in the context of a deteriorating fiscal and regulatory situation in the country. Collecting financial resources for health care became a key question in operating the system, considering that the Orçamento da Seguridade (OSS, social welfare budget) was not complete and financial resources were diminishing.

The guidelines governing the social welfare budget have been changed since the Constitution, not only in terms of funding, but also in terms of the participation of the different social areas in the resources. The health sector, which should be assigned 30% of the total amount of resources, has not received any transfer since 1993. Since then, resources from the Ministry of Health have been subject to instability and irregularities in the monthly cash flow. The separation of health sector and social security financing buried the hopes of health reformers that had been renewed by democratization, of linking the two social areas under the same institutional jurisdiction. At present, social security and health are completely separated from one another.

Another challenge still on the agenda is the change in the health care model. Although the sanitary reform was prompted by major criticisms of the individual, curative model of medical practice, this element no long guides the prevailing proposals in the reform process. In fact, the legal and institutional changes currently proposed focus on the organizational aspects of the system, which do not guarantee the reorientation of medical care.

The priority given to the legal and institutional structure is largely due to the narrow context in which the reform process developed, mainly, the struggle against authoritarian government and for the democratization of society. The segmentation of society in terms of social rights was perpetuated by the authoritarian structure of the Brazilian State. Therefore, the principal focus of attention for the reform proposals was the association between the right to health and the restoration of democracy. In this sense, alteration of the state's legal and institutional structure was of fundamental importance, and would finally prevail over the reorientation of the health care model.

We must also consider that the interests of different health professionals' (physicians, nurses, nutritionists, etc.) in reforming the system are not homogeneous. There is no consensus, within SUS, on the benefits that the various categories of professional should receive, even though, it is obvious that new health care system depends on them. On the other hand, there is still great opposition from the private sector, which adheres to the model of individual, curative care.

In any case, the initiatives outlined in the NOB of 1996, which includes financial incentives for preventive and primary care, may be an important instrument for bringing about changes in the medium term.

Another problematic aspect of the organization-focused reform process concerns the Ministry of Health's doubtful regulation and inspection of health care inputs, particularly drugs and equipment. Initiatives by the public sector to produce low-cost drugs have never supplied a substantial portion of the demand. The political pressures exerted upon the public sector to avoid appropriate regulation, particularly with regard to pharmaceuticals, is well known.

About 2 000 drugs are presently authorized and sold in Brazil, even though most of them are banned in the countries that produced them. Inspection is minimal, resulting in frequent cases of fraud. The country is, for instance, one of the world's largest consumers of amphetamines, which can easily be acquired without a prescription.

Regulation is made all the more difficult by the number and diversity of services provided directly — mainly through private providers, clinics and hospitals, as well as over-the-counter sales of drugs — and the domination of the sector by foreign companies. However, the reform has not yet tackled either the drug issue or the private sector in general. This may be explained by the ideological conditions that prevailed when the reform originated, which precluded any possibility of involving the private sector. More recently, a special national government agency responsible for regulating and controlling drugs and sanitation has been created. Experts doubt that the problems in these two areas can be solved solely by the creation of another agency. Obviously the problem is much more political than administrative. But, as the present health minister has paid special attention to the regulation of the private sector, the agency has already taken important measures, especially concerning drugs.

In short, the principal weaknesses in the sanitary reform process pertain to:

- financing, which includes not only the insufficiency of resources, but also the mechanisms to control expenses and fraud, and the transfer of federal government resources to the states and municipalities;
- conflict of interest between the public and private sectors, and bureaucratic disagreements between the three levels of government (Castro 1992);
- organizational and managerial problems related to adjusting institutions and actors to their new roles; and
- the prevailing curative, individual, hospital-centred model of health care.

Conclusion

In spite of these major limitations, there is no doubt that sanitary reform has had an impact on the democratization of the health sector and on the country as a whole. Never before in Brazilian society has the notion of citizenship included social rights as a basic tenet. Naturally, it is too much to expect that these rights will be fulfilled within a few years, in a country with a long history of denying them. Nor can the historical dependence of social policies upon the variations in politics and the economy be eliminated overnight. In fact, the current juncture has not been favourable to its effectiveness because Brazil has followed the world-wide trend toward separating economic policies from social policies, with clear losses for both.

The democratization of health has also altered the pattern of political interference in Brazil, where the authoritarian profile of the country always prevailed. The fact that the principal periods of economic and social expansion took place under authoritarian regimes meant that represented interests were always limited to a few groups, allowing obscure relationships between the public and the private sectors.

The effect on social policies was a segmented pattern of rights, or rather privileges, granted to specific groups. Negotiating to change these privileges into guaranteed rights had always been the predominant modus operandi of Brazilian society and moulded the notions of citizenship and social rights. The sanitary reform process diverged from this pattern by introducing mechanisms of democracy that were responsible for altering the traditional forms of political negotiation in the social sector.

Establishing civil society and social participation by means of various decentralized institutions, has actually resulted in the creation of a number of innovative forms of health system management. Although its effect is less apparent in health outcomes, it has already changed the culture in terms of the role of the state and civil society in governance.

Thus the effect of Brazilian health care reform is undoubtedly much more evident in the political than in the health sphere. It has been more effective in democratizing the health sector than in changing the epidemiological profile or improving health indicators, leading to the conclusion that democratization was actually its main goal.

The process is not finished yet. Nevertheless, it seems to have increased the distance between democratization and health, which was so clearly related when the process began. In other words, there is no guarantee that democratization will guarantee better health.

Chapter 5.
Reorganizing the Health Care System in Brazil

Lenaura Lobato

Introduction

This chapter will analyze the effects of health care reform, as described in the previous chapter, on the organization of the health care system in Brazil.

Part I will present some general socio-demographic and epidemiological information on the population. It will then describe the major structural characteristics of the system concerned with financing and delivery, as well as the structure of the main subsystems within the health care system as a whole.

Part II will analyze the changes brought about out by the reform by reviewing the dynamics of the health care systems that prevailed from the 1970s to the 1980s and throughout the 1990s, with respect to financing, modes of payment, management, and regulation.

Structural Features

Socio-demographic and epidemiological aspects

During the last two decades, Brazil has undergone major socio-demographic changes. According to the censuses, the Brazilian population grew from 93.14 million to 146.83 million from 1970 to 1991, an increase of nearly 58%. During the same period, the proportion of the population living in urban areas grew from 55.9% to 76.0%.

The composition of the population has also changed significantly. First, there is clear evidence that the population is aging. In 1970, individuals under 20 years of age represented more than 50% of the total population. Now, they make up less than 45%, even though the rate of child mortality in the period has decreased from 95.0 to 49.7 per 1 000 live births. This is mainly due to a decrease in fertility and rise in life expectancy. The fertility rate fell from 5.76 to 2.66 between the two censuses. At the same time, life expectancy rose from 52.49 to 65.62 years (Tables 1 and 2).

Although the aging of the population is a common trend in many developing countries, the distinctiveness in Brazil is the speed with which it has occurred. The effects are already evident in the epidemiological profile of the population and in health care demands. Nevertheless, it is only recently that this new population profile has been taken into consideration by social and health

Table 1. Socio-demographic dynamics — Brazil.

	1970	1991	% increase
Population, millions (a)	93.14	146.82	57.64
Urbanization rate (b)	55.92	76	35.91
Literacy rate (b)	60.34	73.38	21.61
Infant mortality rate per 1 000 live births (b)	95	49.7	47.68
Life expectancy at birth (b)	52.49	65.62	25.01
Fertility rate (b)	5.76	2.66	53.82

Sources: (a) Fundação IBGE (1970b, 1991b)
(b) Fundação IBGE (1995) and World Bank (1993).

policymakers. The issue is not yet well understood and strategies to deal with it are still in their infancy. Moreover, the epidemiological characteristics vary considerably between the various regions of the country: for example, life expectancy on the North is still about 55 years.

The epidemiological profile of the Brazilian population has also gone through major changes and is now more complex than ever, including both chronic diseases and a persistence of diseases associated with poverty and social inequality (Table 3). Infectious and parasitic diseases no longer feature among the main causes of mortality in the country as a whole, but are still important in the poorest regions. On the other hand, deaths from external causes are rising, reflecting a major problem of violence in urban areas and in areas of intense conflict over possession of land.

The percentage of deaths from unknown causes remains high, indicating a deficiency in the reporting system. In some states, more than 50% of all

Table 2. Distribution of population by age — Brazil.

Age groups (years)	1970 (%)	1991 (%)	% Change 1970-91
0-4	14.83	11.25	–24.14
5-9	14.45	11.86	–17.92
10-14	12.73	11.61	–8.79
15-19	11	10.22	–7.09
20-24	8.89	9.23	3.82
25-29	6.98	8.6	23.2
30-39	11.55	13.98	21.04
40-49	8.68	9.5	9.45
50-59	5.62	6.4	13.88
60-69	3.23	4.36	34.98
70 or over	1.83	2.93	60.11
Age unknown	0.2	—	—

Source: Fundação IBGE (1970a, 1995).

Table 3. Principal causes of mortality — Brazil.

1979	1985	1991	1995
Cardiovascular diseases	Cardiovascular diseases	Cardiovascular diseases	Cardiovascular diseases
Symptoms and diseases of uncertain definition	Symptoms and diseases of uncertain definition	Symptoms and diseases of uncertain definition	Symptoms and diseases of uncertain definition
Infections and parasitically diseases	Injuries	Injuries	External causes
Injuries	Neoplasms	Neoplasms	Neoplasms
Neoplasms	Respiratory diseases	Respiratory diseases	Respiratory diseases

Source: Data from the Internet homepage of Ministério da Saúde, Datasus (data system of the Sistema Unico de Saúde), 1997.

registered deaths are attributed to uncertain causes. This high percentage is probably due to infant mortality and deaths from infectious or parasitic diseases. But it may also be indicative of lack of access to and use of health services.

Social inequality thus remains the main health and social policy issue in Brazil. Although the ninth largest economy in the world, the country's social indicators are still cause for concern. According to the United Nations Report on Human Development (IPEA 1996), in 1995 Brazil ranked one of the worst of 55 countries in terms of social inequity. The average income among the richest 10% was about 30 times the average income among the poorest 40%. In most countries this ratio is usually 10 times at most.

Moreover, there has been a rise in the concentration of income, even though the number of people with no income or whose income was less than the official minimum wage decreased. Two phenomena must be mentioned here. The first is that all strata of society enjoyed an increase in income following periods of economic. This increase was greater, however, at the upper-income levels. Thus, it is correct to say that in Brazil there was a direct relationship between the growth of the economy and the growth of total income. This was without doubt a major factor in reducing poverty. But, it is also correct to say that economic growth did not reduce social inequalities. On the contrary, it concentrated income in the higher income brackets. The proportion of total

Table 4. Income distribution — Brazil.

Year	Richest 20%	Poorest 50%
1960	54	18
1970	62	15
1980	63	14
1990	65	12

Source: Barros et al. (1995), cited in *IPEA* (1996).

income of the poorest 50% of the population has decreased continuously between 1960 and 1980, in contrast to that the richest 20% (Table 4).

The other phenomenon worth mentioning is the so-called urbanization of poverty. This means that poverty is no longer predominantly rural, but that the majority of poor people are now concentrated in urban areas. There are also vast differences between the various regions of the country, where the number of poor people is related to other social indicators. The human development index confirms these differences. Although the southeast region may be compared to the countries of high human development, the northeast is comparable to a country of low human development (Table 5).

Table 5. Poverty by regions — Brazil.

	Number of poor (thousands)	% poor	Partici-pation in country	GNP per capita ($)	Life expectancy at birth (%)	Literacy rate (%)	Human development index
North	2 220	43.2	5.3	3 747	68.4	75.4	0.706
Metropolitan	395	43.4	0.9	—	—	—	—
Urban	1 825	43.2	4.4	—	—	—	—
Northeast	18 894	45.8	45.1	2 559	59.1	62.4	0.548
Metropolitan	3 187	43.4	7.6	—	—	—	—
Urban	7 745	43.8	18.5	—	—	—	—
Rural	7 962	49.1	19	—	—	—	—
Southeast	13 988	23	33.4	7 212	68.8	87.7	0.838
Metropolitan	7 481	26.9	17.8	—	—	—	—
Urban	4 519	17.7	10.8	—	—	—	—
Rural	1 988	27.1	4.7	—	—	—	—
South	4 349	20.1	10.4	5 388	70.9	88.2	0.844
Metropolitan	855	17.6	2	—	—	—	—
Urban	1 879	16.8	4.5	—	—	—	—
Rural	1 615	28.9	3.9	—	—	—	—
Centre-East	2 469	24.8	5.9	5 440	69.1	83.3	0.826
Metropolitan	343	22.4	0.8	—	—	—	—
Urban	1 492	23.2	3.6	—	—	—	—
Rural	633	31.8	1.5	—	—	—	—
Brazil	41 919	30.2	100	5 240	66.3	79.9	0.797
Metropolitan	12 261	28.9	29,2	—	—	—	—
Urban	17 198	26.8	41,7	—	—	—	—
Rural	12 198	39.2	29,1	—	—	—	—

Source: *IPEA* (1996).

The data on education show a substantial change in the last two decades, with the literacy rate rising from 60.3% to 73.4% (Table 1). Here too, however, the differences between regions are impressive. In rural areas in the northeast, for example, 67.6% of heads of families are illiterate (IPEA 1996). Among children, there has been a 10% increase in the rate of education between 1981 and 1991, but there are still 4 million children from 7 to 14 years of age who do not go school. Also, although the great majority (97%) of children from families whose income is more than twice the minimum wage are students, this percentage declines to 75% among children from poor families (IPEA 1996).

Social and health expenditures

The data available on social and health expenditures in Brazil must be interpreted carefully. Nevertheless, they indicate important changes. A recent study by the Comisión Económica para América Latina (CEPAL 1997) shows that, in social areas (education, health, and social security), expenditures grew from 12.5% of GNP in 1980-81 to 17.7% in 1990-95. During the same period, the per capita expenditure grew from US $143 to US $386 (Table 6).

Official data on private expenditure is provided through income tax declarations. It is therefore biased in scope toward the wealthy, who are more likely to file tax returns. The increase noted in social expenditure is certainly due to an increase in private expenditure. Although per capita social expenditure

Table 6. Social and health expenditure — Brazil.

	1980-81	1982-89	1990-95
Education	2.9	3.5	4.6
% GNP	33.5	57.7	100.5
Per capita	11	10.7	12.9
% public expenditure			
Health			
% GNP	3.2	3.5	4.6
Per capita	36.3	58.5	100.5
% public expenditure	12	10.8	12.8
Social security			
% GNP	6.4	6.6	8.5
Per capita	73.3	108.8	185.6
% public expenditure	24.1	20.9	23.9
Total social expenditure			
% GNP	12.5	13.6	17.7
Per capita	143.1	225.0	386.6
% public expenditure	47.1	42.4	49.6

Source: *CEPAL* (1997).

increased about 170% during the period, the public portion of it did not increase more than 5.5%.

Recent research on household income and expenditure confirms that there has been a significant increase in private expenditure over the last decade, at least for education and health. Health expenditure has tripled as a proportion of the Brazilian household expenditure (IBGE 1997).

Health expenditures have, in fact, followed the trend of increased social spending, with a decrease in the proportion spent on public health services. Per capita expenditure on health grew from US $36.3 to US $100.5 between 1980-81 and 1990-95, or about 177%. This is even more than the growth in per capita expenditure on social services as a whole. The increase in public health expenditure was only 6.6%.

Table 7. Public expenditure on health (US$ per capita, 1990) — Brazil.

1980	1891	1982	1983	1984	1985	1986	1987	1988	1989	1990
81.44	75.44	76.64	61.7	61.04	71.57	78.35	92.06	77.34	100.89	87.87

Source: World Bank (1995).

This trend can be confirmed by considering only the public expenditure per capita, which did not increase, but was subject to wide fluctuations between 1981 and 1990 (Table 7). These fluctuations were even more evident in the spending pattern of the Federal Government (Table 8).

Table 8. Central government expenditure on health (% of total revenues) — Brazil.

1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
11.9	11	10.5	9.5	12.2	10.9	9.7	14.8	15.7	16.8	13	13.2	10.8

Source: Médici (1993).

Two other important aspects must be noted in the process of health care reform. First, a considerable increase in expenditure occurred in 1987 as a result of the decentralization begun during the 1980s. In 1990, however, there was a decrease that corresponded to the first year of the first elected government after the military regime, when social and health expenditures were cut considerably. The other important feature is the effect of decentralization on the increase of expenditures by municipalities, evident in Table 9.

Table 9. Public expenditure on health (%) by government level — Brazil.

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Government	74.88	73.87	74.38	72.34	74.60	71.65	68.76	83.06	91.34	77.45	72.73
State	17.81	18.50	17.21	19.13	17.95	18.85	20.78	8.86	-6.11	11.60	15.43
Municipal	7.19	7.62	8.39	8.51	7.43	9.48	10.44	8.06	14.77	10.93	11.83

Source: Data calculated from World Bank (1995).

Coverage

The Constitution of 1988 gave the entire population the right to use any public health service in the country. In reality, it is estimated that the public system covers about 70% of the inhabitants. This percentage was calculated by estimating the proportion of people who have any kind of private coverage and therefore do not use public system. Some of them, however, are known to use public services for procedures not covered by their private plans.

The data on the private health sector are not official. According to the associations of private health companies, 42 million people are affiliated with some kind of voluntary health plan. They are mostly employees in the formal market, mainly in the industrial and services sectors, who are entitled to coverage through the companies they work for. Some are families or individuals who contract directly for private service.

Some people in the voluntary health sector are covered by more than one private company, as well as by the public system. An individual may have more than one employer, may be a dependent of more than one entitled person, and may also be covered by a health plan contracted directly, to complement an employer's plan. The following paragraphs describe the private health sector in more detail.

Subsystems

The Brazilian health care system may be divided into two subsystems. The first, the Sistema Único de Saúde (SUS, unified health system), incorporates a host of public providers and comprises hospitals and primary health centres that belong to federal, state, and local governments. It also includes private profit and nonprofit providers under contract to the public system.

The second system is known in Brazil as the "supplementary medical system." It includes the private plans with voluntary affiliation as well as prepaid health plans and insurance companies.

Unified health system

According to the Constitution of 1988, the Sistema Único de Saúde (SUS, unified health system) comprises all health care and services provided by public institutions of the three levels of government, as well as private institutions that provide services under contract. In principle, the whole population is entitled to universal health care. SUS is regulated by the Lei Orgânica da Saúde (LOS, Health Organization Law), which is actually two laws — Law 8.080 and Law 8.142 — both passed in 1990.

Responsibility for SUS is shared by the three levels of government — the Ministry of Health and the state and municipal councils, as well as their respective secretariats, which comprise an equal representation of providers and users. Integration between the different levels of government is carried out through an inter-management commission, composed of authorities from each.

The Constitution of 1988 determined that SUS should be financed from the social security budget, which is funded through salary-based compulsory contributions by employers and employees; general taxation through federal, state, and municipal budgets; and other sources.

Because neither the Constitution nor the social security budget specifies the amount of resources designated for health, the Lei de Diretrizes Orçamentárias (LDO, budget directives law) has fixed a minimum equal to 30% of the social security budget. This minimum has not been met, however, since 1993, when the Social Security Institute suspended the transfer of resources to the Ministry of Health. This caused a deep financial crisis in the sector. In 1992, for instance, resources from compulsory contributions represented 55% of the public budget for health.

From 1993 on, SUS began to rely upon extraordinary contributions and central government transfers to make up its budget, which amounted to 60% of its total resources in 1995. A special tax on banking transactions was imposed in 1996 to solve the problem. On the other hand, states and municipalities have increased the allocation of their own resources to finance the system.

Supplementary medical system

This system includes various models of private prepaid health plans and health insurance companies. It enrolls people voluntarily or employees through contracts with their firms. Although legally all the health services rendered in the country come under the framework of the Sistema Único de Saúde (SUS, unified health system), the supplementary medical system is still not integrated with SUS. Also, regulation of this system has only very recently come under the responsibility of the public health authorities.

Because of this lack of regulation, information about this subsystem is very sketchy. Estimates consider that it includes, at present, some 1 360 companies, with 42 million beneficiaries. Its total revenues are estimated at US $14.8 billion (Table 10).

There are four main types of supplementary medical coverage: group medical companies, medical cooperatives, health insurance companies, and self-managed health plans. This last type of plan deals exclusively with health services for the employees of a given enterprise, usually a large public or private

Table 10. Coverage and revenues of the voluntary contract subsystem, 1989-96 — Brazil.

	1989				1996			
	Insured inhabitants (thousands)		Revenues (US$ millions)		Insured inhabitants (thousands)		Revenues (US$ millions)	
Private service	Number	%	Number	%	Number	%	Number	%
Medicine groups	17 250	55.3	1 000	42.2	17 300	40.9	3 700	25 .0
Medical cooperatives	5 110	16.4	567	23.9	10 000	23.6	3 500	24 .0
Self management and administrative plans	7 898	25.3	659	27.8	9 000	21.3	4 600	31 .0
Health insurance	944	3.0	146	6.1	6 000	14.2	3 000	20 .0
Total	31 202	100.0	2 372	100.0	42 300	100.0	14 800	100.0

Source: Médici (1990), Abramge and Folha de São Paulo, 14 Sep. 1997.

corporation. It often offers a larger variety of services, including dental care. In recent years, the other types of supplementary medical plans have tended to become more homogeneous in terms of their service offer, contract options, and forms of payment to providers.

Group medical practice companies offer prepaid plans in which the services differ according to the contract made. The services may be provided through a network of facilities and professionals belonging to the company; free choice of provider followed by reimbursement; or through various combinations of the two. Premiums are paid monthly and prorated by age. In 1996, there were 700 companies, with 17.3 million people enrolled. Their revenues were approximately US $3.7 billion.

Medical cooperatives are organized by professionals to render services based on prepaid arrangements. They work in a way similar to the group medical companies, although they restrict the use of services to their own professionals. On the other hand, they usually offer a larger number of providers. In 1996, there were 320 enterprises, with 10 million people enrolled. Their revenues were approximately US $3.5 billion.

Health insurance companies function rather differently in Brazil than in some other countries, because they incorporate both the functions of reimbursement and service delivery. Although they are based on a free-choice system, most of them offer a network of services and professionals, which makes similar to the previous systems. Their growth in recent years is due to the enrolment of large enterprises, which in the past bought services from the previous two models. Even more recently, traditional financial institutions have assumed part of this market through association with firms providing smaller insurance plans. In 1996, there were 40 such companies, with 6 million people enrolled. Their revenues were about US $3 billion.

Self-managed plans allow employers to offer employees and their families access to health services through differentiated assistance plans. They use two models: either they enroll providers, creating their own network of services, or they contract the services from another firm, which acts as a intermediary responsible for the management of services. This method is increasing and has stimulated the growth of the so-called "representation" companies, acting as intermediaries between payers and providers.

Organization and provision

Health facilities

This section will describe the general characteristics of the whole health care system. The data are presented according to the type and ownership of the health units, public or private, and not according to their financing or management. Thus, private sector here refers to the ownership of the unit, whether the public or the private sector finances the service. This distinction is important because privately owned units provide the majority of services financed by the Sistema Único de Saúde (SUS, unified health system).

In 1990, Brazil had 35 701 health facilities, including basic units, health centres, polyclinics, emergency clinics, and hospitals (Table 11).

The public sector comprises the largest network of primary health care providers, especially in the poorest regions. On the other hand, most of the secondary and tertiary health institutions (polyclinics and hospitals) are private, and are located in the most affluent and populated regions. In some of these areas, the predominance of private hospitals is very high. For example, in the state of Sao Paulo, 82% of the hospitals belong to the private sector. Public hospitals, particularly those that offer tertiary care are, however, better equipped and possess the most advanced technology.

Table 11. Health facilities — Brazil, 1990.

Classes	Public			Private			Total		
	n	%	%(a)	n	%	%(a)	n	%	%(a)
Basic units	6 038	25.0	98.0	131	1.0	2.0	6 169	17.0	100
Health centres	14 129	59.0	98.5	189	2.2	1.5	14 318	40.0	100
Polyclinics	2 126	11.0	25.5	6 170	52.0	74.5	8 296	23.0	100
Emergencies	188	0.7	65.5	98	0.8	34.5	286	0.8	100
Hospitals	1377	6.0	21.0	5 155	43.5	79.0	6 532	18.0	100
Total	23 858 (67%)	100.0		11 843 (33%)	100.0		35 701 (100%)	100.0	100

Source: Fundação IBGE (1976, 1992)
(a) Roll %

This distinction between the public and private sectors is more evident when we consider hybrid institutions such as health centres, which provide both primary and secondary care. This kind of establishment fulfills the need for services in rather simple units with a few beds to provide general care, minor surgery, and gynecological and emergency services. In Brazil, such health centres are predominantly public and concentrated in the poorest regions. Emergency units, too, occur primarily in the public sector.

The private sector owns the majority of small- and medium-sized health facilities, but it is particularly involved in hospital ownership. Recently, however, it seems that the private sector is following the international trend toward reducing the number of large general hospitals in favour of small, specialized units.

Beds

During the period under study, two main changes occurred concerning beds. The number of beds increased in absolute terms while the number of public beds decreased, indicating a trend toward the growing predominance of the private sector in inpatient care. In 1976, public beds made up 26.8% of the total, but in 1992, they made up only 24.8% (Table 12).

Table 12. Beds in hospitals by subsector — Brazil.

	1976		1992		Change 1976-92
	n	%	n	%	%
Public	119 062	26.82	135 080	24.81	13.5
Private	324 826	73.18	409 277	75.19	25.98
Brazil	443 888	100.00	544 357	100.00	22.63

Source: Fundação IBGE (1976, 1992).

The other important change was the growth in the number of public beds at the municipal level. The municipalities were, in fact, responsible for the growth in the number of public beds during the period, Indeed, the number of municipal public beds increased by 238%, while the number of federal public beds decreased by 14.9%, and the number of state public beds by 6.6% (Table 13). Many of the federal and state facilities were transferred to municipalities, but the latter also invested in new units and renovated others.

The two changes are both consequences of the reform process. On the one hand, the reform process stimulated the privatization of health services and, on the other, strengthened the role of local government in providing health services. However, only the latter was actually outlined in the reform proposals, through the principle of decentralization.

Table 13. Public beds in hospitals per government level — Brazil.

	1976		1992		Change 1976-92
	n	%	n	%	%
Federal	27 982	23.5	24 072	17.82	−14.9
State	80 476	67.6	75 147	55.63	−6.6
Municipal	10 604	8.9	35 861	26.55	238.0
Total	119 062	100.0	135 080	100.00	13.5

Source: Fundação IBGE (1976, 1992).

Hospitalization

Paradoxically, the decrease in the number of public beds was accompanied by an increase in the number of public hospitalizations. The percentage of hospitalizations in public units increased from 15.6% of the total in 1976 to 23.3% in 1992, for a relative growth of 49.3% (Table 14), while the participation of private units in the number of hospitalizations decreased from 84.4% to 76.7%, or by 9.1%.

Table 14. Hospitalizations by subsector — Brazil.

	1976		1992		Change 1976-92
	n	%	n	%	%
Public	1 872 440	15.58	4 622 480	23.27	146.9
Private	10 149 509	84.42	15 241 961	76.73	50.2
Total	12 021 949	100.00	19 864 441	100.00	65.2

Source: Fundação IBGE (1976, 1992).

Actually, the increase in public hospitalizations was only apparent, caused by the new form of payment within the Sistema Único de Saúde (SUS, unified health system). After 1990, all services delivered by public and private providers began to be paid under the same system. This led to a change in reporting because the public units, which had previously been financed through budgets, now had to itemize services rendered in order to get paid. As well, many private providers stopped serving SUS because it reduced the prices it paid for services.

Office visits

The public sector has always been responsible for most of the office visits in the country. However, in the period under study, its relative weight also decreased when compared to the private sector. In 1976, 61.7% of office visits were provided through public units, whereas in 1992 the percentage was 59.7% (Table 15).

Table 15. Distribution (%) of office visits — Brazil.

	1976	1992	Change 1976-92
Public	61.66	59.75	−3.1
Private	38.33	40.24	5.0

Source: Fundação IBGE (1976, 1992).

Human resources

The ratio of doctors per 1 000 inhabitants in Brazil was 1.46 in the period from 1988 to 1992 (World Bank 1993). The doctors were very unevenly distributed among regions and between urban and rural areas, with a clear concentration in the cities. Recent research shows the ratio of doctors per 1 000 inhabitants in rural areas as 0.53, whereas in urban areas it reached 3.28 (CFM/FIOCRUZ 1996).

The ratio of registered nurses-to-doctors, was 0.1 during the same period (1988-1992), lower than the average in Latin American countries (World Bank 1993). The human resource structure still retains some biases inherited from the 1960s and 1970s, when the demand for physicians grew quickly and the system responded by increasing their numbers. When considering practical nurses, the difference is also high: in 1992, there were still nearly twice as many doctors as non-registered nurses — 171 561 doctors to 95 027 nurses (Table 16) — a minor increase over the growth in the number of doctors.

Table 16. Human resources[a] — Brazil.

	1976		1992		% Change 1976-92	
	Public	Private	Public	Private	Public	Private
Physicians	54 201	62 259	65 205	106 356	20.3	79.8
Nurses	30 833	40 200	46 785	48 242	51.7	20.0

Source: Fundação IBGE (1976, 1992). [a]Numbers of jobs.

The private sector continues to employ an increasingly higher proportion of doctors than the public sector. During the period under study, the number of doctors employed in both sectors grew by 47.3%. However, the number of doctors in the public grew by 20.3% while the number of doctors in the private sector grew by 79.8%.

Evidence of the growing importance of supplementary medical care within the private sector is that at least 75% of the doctors were totally dependent on the services provided to these companies (CFM/FIOCRUZ 1996).

Transformations in the Health Care System

Health care reform in Brazil has succeeded in changing the health system's organization. According to the categories used by the Organisation for Economic Co-operation and Development (OECD 1992), the health care system that prevailed from the 1970s to the 1980s was composed of three subsystems: a public contracting subsystem, the predominant one of the period; a public integrated subsystem, which was secondary; and a voluntary contracting subsystem, which was marginal.

The present system comprises a public contracting subsystem, resulting from the fusion of the two former public subsystems into a single new one; and a voluntary contracting subsystem, with a more important role to play in the provision of services.

Although a new system is emerging, it has not yet taken on a definite shape because the process of reform is not yet over. There are many ongoing changes that can only be expressed by comparing the dynamics of the subsystems before and after the reform.

To best present these dynamics, the subsystems will be described in terms of the relationships between payers and providers, between patients and providers, and finally between the population and the payers.

Organization of the health care system — 1970s to 1980s

During this period, three systems existed: a public contracting subsystem; a public integrated subsystem; and a voluntary contracting subsystem.

The public contracting subsystem was funded by compulsory salary-based contributions from employers and employees. Entitlement was restricted to people who paid contributions and their families. Services were provided through public facilities owned by social security and through other public or private providers with direct contracts from the payer. Payment for services was varied according to the type of provider and type of service rendered.

The public integrated subsystem was financed through general taxation. Providers were paid through prospective budgeting and salaries.

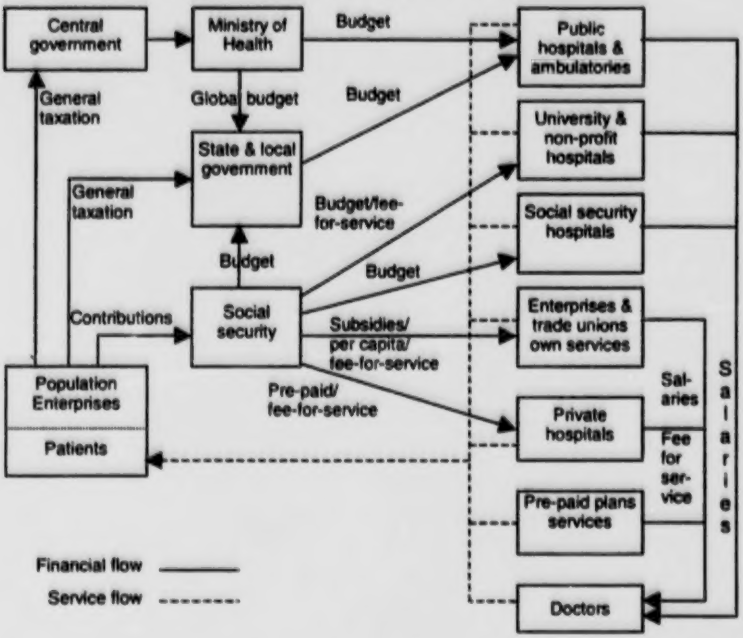
Although they were supposed to function under a single system, until the reform these two subsystems were totally independent from one another. They differed in terms of financing, payment of providers, range of services delivered, and entitlement (Figure 1).

The Ministry of Social Security and Social Assistance was the central institution in the public contracting subsystem. Its main agency, the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security), was established in 1977 and responsible for contracting and providing individual health care throughout the country.

The Ministry of Health was the central institution in the public integrated subsystem, in charge of public health and providing services related to prevention and chronic diseases.

The third subsystem was the voluntary contracting subsystem. It was limited to some large public and private enterprises that provided services to

Figure 1. Brazilian health system in the 1970s.


Central government
Ministry of Health
Budget
Public hospitals & ambulatories
General taxation
Global budget
Budget
State & local government
University & non-profit hospitals
General taxation
Budget/fee-for-service
Social security hospitals
Budget
Budget
Contributions
Social security
Enterprises & trade unions own services
Subsidies/ per capita/ fee-for-service
Population Enterprises
Patients
Pre-paid/ fee-for-service
Private hospitals
Sal-aries
Fee for ser-vice
Salaries
Pre-paid plans services
Financial flow
Service flow
Doctors

employees and their families, directly or through contracts with medical care providers. Employers, employees, and social security participated in financing the system. In exchange for not having to provide services to these beneficiaries, social security transferred a fixed amount per insured person to the enterprise through INAMPS. There were few enterprises with this type of agreement with social security (122 in 1977) and the agreements were suspended in 1979. Although fairly insignificant in the voluntary contracting subsystem, this form of contract was the model for the group medical companies that have become the main type of provider within the present voluntary contracting subsystem.

Relationship between payers and providers

In the public contracting subsystem, there was only one financing entity: the social security agency, Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security). The type of provider determined the form of payment, and regulation was restricted to the services established under contract. For the network of hospital and primary health centres owned by social security, the means of payment was an annual global budget, established by the central government according to historic expenditures. The professionals were paid salaries.

Private hospitals were the main providers. Their services were contracted directly by INAMPS to provide services to social security beneficiaries. Payments were preset on a fee-for service basis. Fee-for-service financing stimulated the use of services and poor management by INAMPS made it vulnerable to fraud. Contracts were not clear about objectives and results, there was almost no supervision, and no limits were set on providing services. To be reimbursed for complementary services or equipment that a provider had to buy from another provider, such as a prostheses for example, the provider needed only to present a receipt. The prices for the same product could vary by as much as 600% between regions (Cordeiro 1991).

Prices for services were defined by INAMPS, but the negotiations included participation by representatives of providers. The relationships between the association of private hospitals Federação Brasileira de Hospitais (FBH, Brazilian federation of hospitals) and INAMPS provides an example of the special relationship between the bureaucracy and private interests that existed during the dictatorial period and was known in Brazilian sociology as "bureaucratic rings" (Cardoso 1977). The significance of the sums paid by INAMPS to the contracted providers can be seen in the fact that 90% of the services delivered in the country were directly or indirectly related to that agency. Moreover, between 1969 and 1975, 90% of agency expenses were allocated to pay for services provided under contract.

During the social security crisis of the 1980s, limits were set on payments for services, in spite of strong resistance by doctors and private institutions. Private sector profits fell considerably. The constant devaluation in the price of services carried out during this decade was the main reason the private sector lost interest in providing services to social security. However, this process only became significant in the second half of the decade.

INAMPS also contracted for services provided by states and municipalities to their own civil servants; by professional associations to their members; and by public universities and nonprofit institutions for social security beneficiaries. These contracts were actually agreements between INAMPS and the providers. For states and municipalities, payments were based on global transfers and for nonprofit institutions and associations on fixed incentives.

The universities, although public, were governed by the Ministry of Education and paid on the basis of hospital admissions. The agreements with the universities had been important as a political instrument in the question of favoring private or public providers; however, their capacity to provide complex and specialized services was abused because they ended up taking on the patients with expensive-to-treat conditions who were refused by the private sector.

Nevertheless, these providers (states and municipalities, professional associations, public universities, and nonprofit institutions) had a minor share within the system compared to the for-profit private sector. Only the rural syndicates turned out to be of significance, once rural workers were included as beneficiaries of social security.

Finally, another type of contract was established directly between INAMPS and the doctors — specifically the general practitioners, pediatricians, gynecologists, and obstetricians — in a given region. They worked in their own private clinics and were paid under fee-for-service agreements.

Various changes were carried out within the public contracting subsystem throughout the 1970s and particularly after the fiscal crisis in social security. Changes in the payments to providers, in the people insured by social security, and in the providers enrolled altered the proportions of the different providers in the total expenditures of INAMPS.

For example, in 1981, prior to the introduction of restructuring measures, the roles of providers and forms of payment were as described earlier. In that year, INAMPS' health expenditures were as follows: 61.4% to for-profit private hospitals; 20.5% to social security's own services; 2.5% to universities; 5.7% to other central government agencies; 3.7% to nonprofit private institutions; 3.4% to businesses; and 2.85% to associations. This distribution shows the importance of the private sector in the provision of health services in the country.

Under the public integrated system, the provision of services was very restricted because of the low priority assigned to health care activities affecting major portions of the population and to preventive health. Payments by salaries and global budgets, as well as the tidy and bureaucratic structure of the Ministry of Health, also contributed to restricting the relationship between payer and providers to the bureaucratic hierarchy within the Ministry of Health.

The voluntary contracting subsystem had, as its main providers, medical groups contracted by businesses to provide services to their employees. For the medical groups, services were prepaid on a per capita basis; for hospitals, on a per diem rate for inpatient care and on a fee-for-service basis for outpatient care. This subsystem was quite small until the second half of the last decade.

Relationship between patients and providers

The contributions required by social security for insurance and guaranteed access to health care divided the population into the insured and the uninsured, each receiving different levels in terms of type of services and quality of care.

Until 1966, social security services were restricted to the members of specific professional categories, and people with the highest incomes received the best services. Many of these differences were maintained, even after the unification of the former Institutos de Aposentadorias e Pensões (IAPs, retirement and pension institutes) into a single institution, based primarily on the political influence of certain professions or occupational categories.

The process carried out during the 1970s that extended coverage to new groups of people did not end the differences. On the contrary, it deepened them. As the extension of coverage was not accompanied by a change in the system's funding, nor a change in the structure for providing service, a good part of it remained restricted to the people who were originally insured. This segmented provision structure provided better quality service to the top sectors of the workforce — public servants and the military — and poorer quality service to the recently insured — rural, domestic, and self-employed workers. The rest of the population continued to depend on the scarce public services of the Ministry of Health or on charitable institutions.

In 1974, coverage for emergency care was extended to the whole population. The demand increased, not only in terms of volume but also in terms of range, as people quickly learned to turn every situation into an emergency. This new demand was covered mainly by private providers. The lack of control associated with the fee-for-service mode of payment encouraged a curative, hospital-centered approach to care, resulting in the misuse or "over-medicalization" of services, particularly on the part of the uneducated, and especially low-income, groups.

The crisis in the 1980s and the deep cutbacks in expenditures meant that the quality of health care deteriorated. With the devaluation of the fees for services, private providers became selective with regard to the types of patients and mix of cases that they would take on, with a view to maximizing their profits. Although all providers were supposed to care for the newly insured, private providers began to send these patients to publicly owned services, which had not been properly restructured. Successive strikes by doctors and health professionals in the public sector during this decade strained their relationship with the population. Better quality health care became an issue for social change during this period.

Indeed, never before had health issues been as important to Brazilians as they were in the 1980s. However, demands were not directed mainly at providers. Because of the centralized, obscure relationship between the principal payer, the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security), and the providers, the public did not make a distinction between them, and directed its demands for change toward the government.

Relationship between population and payers

During this period, the right to health care became the main preoccupation of the population, because of the strong affiliation between payers and providers under both the public contracting and the public integrated subsystems.

Better-organized groups distrusted the measures adopted during the 1980s to combat the social security crisis, which aggravated previous restrictions on services. However, the deterioration in the quality of services prompted these groups to support the proposals for reform, including the introduction of a universal system. Nonetheless, this support was followed by a search for agreements with businesses to get extra insurance from the voluntary contracted subsystem.

Organization of the health care system in the 1990s

At present, the health care system is composed of a public contracting subsystem — the result of the fusion of the two former public subsystems — and a voluntary contracting subsystem with different characteristics from the previous one.

The public contracting subsystem corresponds to Sistema Único de Saúde (SUS, unified health system) and the voluntary contracting subsystem corresponds to the supplementary medicine system as described in the first part of this chapter.

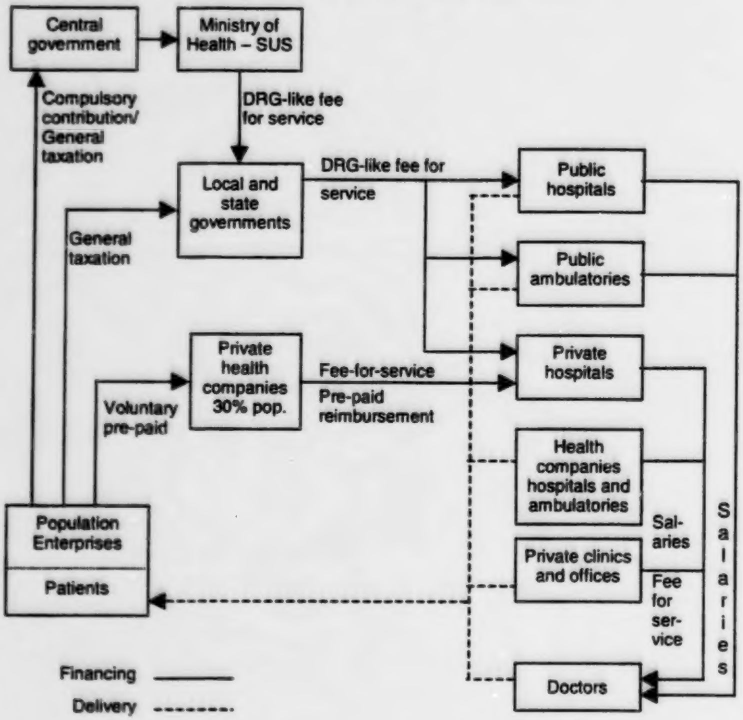
Within the public contracting subsystem, three main changes took place. First, there was the introduction of universal coverage. Second, the public institutions were integrated into SUS, ending the institutional dichotomy of the previous system. Third, changes were introduced to the financing and management of services.

The voluntary contracting subsystem increased and diversified, assuming an important role in the provision of services. New forms of contracts emerged, influencing the organization of the medical system.

The perpetuation of two subsystems with different principles and different conditions of access has not yet solved the problem of health care inequities, nor does it seem to have improved health conditions as whole. However, the mechanisms under which the reform process was carried out, especially decentralization, have contributed to improving the system.

The general configuration of this new system is shown in Figure 2.

Figure 2. Brazilian health system in the 1990s.


Central government
Ministry of Health – SUS
Compulsory contribution/ General taxation
DRG-like fee for service
Local and state governments
DRG-like fee for service
General taxation
Public hospitals
Public ambulatories
Private hospitals
Private health companies 30% pop.
Fee-for-service
Pre-paid reimbursement
Voluntary pre-paid
Health companies hospitals and ambulatories
Population Enterprises
Patients
Private clinics and offices
Sal- aries
Fee for ser- vice
Salaries
Doctors
Financing
Delivery

Relationship between payers and providers

Within the public contracting subsystem, the three levels of government are both payers and providers. The financing is still predominantly federal, although participation by states and municipalities has increased.

Transfers from the federal government to the states and municipalities are based on Normas Operacional Básicas (NOBs, basic operational norms) established by the Ministry of Health, mostly in 1993 and 1996. These principles include mechanisms to decentralize financing, which were vague both in the Constitution and in the Health Organization Law. This was due to resistance on the part of the health bureaucracy, dominated by the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, national institute of medical care and social security) up until 1993. There was also strong resistance on the part of private providers, who did not want to lose their privileged relationship with the INAMPS bureaucracy, and from the municipalities, who were afraid of taking on new responsibilities.

The legal rules published in 1993 and 1996 were to be based on the principle that transfers should be oriented by technical and epidemiological criteria, as well as the needs of the population. However, these mechanisms have not yet been totally implemented, because of difficulties in overcoming the legacy of the previous system. Thus, most transfers are still based on the volume of services rendered, even though two important changes have been introduced. First, there are now limits to expenditures and, second, direct transfer to municipalities specific allocations for primary care activities have been introduced.

There are two basic mechanisms for transferring resources. The first method is through direct, automatic transfer of resources to states and municipalities for primary and ambulatory care and based on population criteria. This type of transfer, although based on the 1996 Normas Operacional Básicas (NOBs, basic operational norms) of the Sistema Único de Saúde (SUS, unified health system) (Ministério da Saúde, 1996), was only authorized by the central government in December 1997. It prescribes the transfer of a fixed amount of 10 Brazilian reals (BR $1.00 = US $1.15 in 1997) per year for each inhabitant of the municipality. Special incentives for municipalities that establish basic primary health programs, such as family doctors, are also prescribed.

The second method consists of transfers for services provided, that is direct transfers to the providers, public or private, for services relating to hospital stays, highly complex procedures, and ambulatory services, especially office visits. Payment for hospital stays and highly complex procedures are based on the Autorização de Internação Hospitalar (AIH, hospital stay authorization), a system similar to the diagnostic-related groups (DRGs) in the United States. The procedures are based on the United Nation's International Disease Classification. Fixed values are established according to the diagnosis and required procedures. Hospitals where highly complex procedures are carried out are paid extra to maintain their structures. Payment for ambulatory services is based on Unidades de Cobertura Ambulatorial (UCAs, ambulatory care units), as well as a fixed amount for each service.

There is an important difference between the two mechanisms for transferring resources. In the first, the municipality gets the total amount to develop basic activities. The second is less a transfer and more a payment for services. Provision is totally dependent on this latter mechanism, which means that an important part of the services rendered is still based on fee-for-service payments, but with limits. On the other hand, what is important is that the same method of payment to public and private providers has been adopted, requiring the same minimum efficiency from both.

The flow of resources is based on the stage of management autonomy attained by the state and municipality involved, as prescribed in the 1993, and more recently in the 1996, basic operational norms. The stage of management autonomy indicates the degree to which the state or municipality is capable of taking over management of health services provision from the federal government. The final objective of SUS is the total autonomy of municipalities in the provision of services. As described in the first section, the basic operational norms of 1993 considered three different management situations, which were actually consecutive stages in achieving autonomy and responsibility.

- The Incipient Management Stage, whereby the municipality formed a Municipal Health Council and a Municipal Health Fund that separated health resources from other public resources. Federal resources, transferred through the states, were deposited in part in this fund, with the amount depending on the contracts, public or private, already signed by the municipality. The municipality also participated in setting the limits for inpatient and ambulatory care payments.
- The Partial Management Stage, in which the municipality participates in the financing and was able to receive the difference between the limits on inpatient and outpatient services and what had actually been spent.
- The Semi-complete Management Stage, whereby the municipality takes on complete responsibility for providing public and preventive health activities, as well as individual health services through public and private providers. Such a municipality received the full amount of resources up to the specified limit.

Since the basic operational norm of 1996 was approved, only two management situations remain: Complete Management of Basic Care and Complete Management of the Municipal Health System. For either of them, the municipalities must fulfill the requirements of the former Incipient Management Situation. The main difference now is in the ability to receive federal resources for the full system or only for basic care. It is impressive the number of municipalities that have qualified for the Complete Management of Basic Care (3 700 between December 1997 and May 1988, or 67% of all municipalities). The prescribed resources doubtlessly represent a lot for most of them. Meanwhile, 412 municipalities have qualified for Complete Management of the Municipal Health System, or 7% of the total.

In municipalities that have not reached either of these management situations, the resources are controlled by the state, which has the responsibility to bring them up to the level of the first management situation.

The relationship between payers and providers has changed with the introduction of the inter-management commissions, which are responsible for setting the amounts of resources for states and municipalities and for establishing their management situation. Financing has become much more transparent, because all levels of government participate in the commissions and because the commissions have strengthened technical support. The representatives of the different governments, in turn, have to account to the health councils, which are legally responsible for health policy, at the executive level.

Although there are huge differences between the states and municipalities, these inter-management commissions have formed a health-management network that has profoundly changed the former pattern of negotiations in the public health system. However, within the whole public contracting subsystem, innovations are restricted to the distribution of existing resources, as none of the inter-management commissions, nor the Ministry of Health, has any say in the amount of resources designated for the sector. This is decided by the Federal Government, specifically, the Ministry of the Treasury. This is why one of the main demands of National Health Council is the establishment of a fixed amount to be transferred to the health sector.

The relationship between government, acting as payer, and private providers has also improved. With the cutbacks in funding and the reduction in service prices, the private providers that continue to maintain contracts with SUS are those that did not succeed in modernizing sufficiently to be able to leave the public sector for the voluntary market. They have, however, lost their political power within the sector. In general, they have adapted to the new role of municipalities, have adhered to the innovations in management and regulation, such as accounting to Health Councils, and have even been partners in the demand for resources. The situation of the nonprofit institutions is similar.

However, the general situation of the private providers contracted to SUS is very bad. The quality of services and the salaries are known as the worst in the public contracting system, and private organizations are still the principal providers of services to SUS.

Some management innovations are introducing new forms of financing for services. Although recent, they will affect the organization of provision and thus the relationship between payers and providers. One innovation is the signing of contracts with third parties to provide services. The government (state or municipality) contracts with a cooperative of professionals to be responsible for care in a certain unit, paid on a per-capita basis by size of the local population. The largest experience to date has been in the city of São Paulo.

Although there has been no conclusive study on these cooperatives, which are different from those in the voluntary contracting subsystem, they have been criticized for their tendency to transfer more expensive patients to other, particularly public, units. Moreover, although they have been contracted as cooperatives of professionals, in fact, many of them are actually a group of professionals that sign the contract but subcontract the work to other professionals. These subcontracted professionals are not members of the cooperative, but rather employees hired for low wages, with no legal right to a share of the profits. This results in little commitment to the service, high employee turnover, and the possibility of professional incompetence. There has been very poor supervision of the cooperatives by the local health secretariats.

The payment of professionals within the public contracting subsystem differs depending on whether the establishment is publicly or privately owned. Public servants were paid a salary and excluded from special contracts under the former system. In some states and municipalities, production incentives were introduced but have not been well evaluated. Although their objective was to improve efficiency and avoid resignations by professionals because of the low salaries, the effect has been a decline in the quality of service because of increased volume.

In the public contracting subsystem, there are still some health units that, for political reasons, maintain different relationships and contracts with SUS. First, some highly specialized public hospitals are financed directly by the Ministry of Health and are managed autonomously, with no interference by the state or municipality. This system is referred to by the term "co-management." Although few in number, these hospitals have considerable resources, and supplement the salaries of their professionals.

Some states and municipalities have been reluctant to integrate with SUS and continue to try to restrict their services to their previous clientele, the civil service and the army. They will, however, care for SUS patients in an emergency. Many of them also have huge financial problems, despite the fact that they are partly financed by the institutions to which they pertain.

Within the voluntary contracting subsystem, financing comes mainly from businesses and families, although expenses are deductible from income tax, which gives them an important indirect contribution through general taxation. Contributions by employees are generally lower than payments for individual insurance. Some businesses offer different plans, and the prices may be higher.

Payments to providers are based on fees for service, according to the fees established by the Associação Médica Brasileira (AMB, Brazilian medical association), one of the associations that represents physicians. The adoption of these fees has been one of the major demands of the corporation since 1987. At present, many companies follow the AMB list of fees, but the larger ones, with many professionals enrolled, generally pay lower fees and take longer to pay.

All companies maintain a fixed number of doctors on salary. They usually have their own units, although this is more common in group-type practices that operate like the health maintenance organizations (HMOs) in the United States.

Health insurance companies have recently begun offering their own services as well, and most of them operate through prepaid plans. The insurance companies are also tending to associate with intermediary agencies that negotiate prices and services with the final providers — clinics, professionals, and doctors. Another recent trend is their association with banks, forming a triangle with health insurance companies and intermediary agencies.

With these associations, companies are able to obtain contracts with large businesses as well as to be competitive in marketing individual plans. This strategy was necessary because buying insurance has never been customary among Brazilian people, and health insurance is the most expensive form of insurance there is.

On the other hand, the medical groups have begun offering the possibility of reimbursement, which is common for insurance companies, and important in attracting upper-income clientele, that does not want to be restricted to the list of services offered.

Relationship between patients and providers

Within the public contracting subsystem, the main conflicts continue to be over access to and quality of health services. The Constitution of 1988 extended health care to a large segment of the population not previously covered, but did not follow up with investments in the health services delivery structure. Although some state and municipal governments have invested considerably in health, the situation country-wide is precarious.

Although the notion of health as a right of citizenship has been accepted, people remain passive about the poor quality of the services. Perhaps the difficulties in gaining access to services have blinded people to the poor quality of services. The fact that people complain about access, but not about service quality, means that these two aspects are still viewed separately.

On the other hand, the innovations in terms of decentralization seem to have already had an effect on services that is felt by the population. A recent public opinion survey rated municipalities under the Semi-complete Management

Stage higher than others in terms of improvements in health services. Public health services were more frequently identified as a problem in municipalities that had yet to reach any stage of management autonomy. (Instituto Gallup 1996).

Nevertheless, although well received by the population, the decentralization process may have medium- or long-term effects that are already evident in some places. These are related to differences in investments between localities. There are cases where neighboring cities have huge differences in health care provision, sometimes simply because one government is improving services and the other is not. People are attracted by the better services, and because access is universal, the locality begins to feel the increased demand and begins to create mechanisms to make access more difficult. These problems are the responsibility of the states; however, initiatives to resolve them are still hard come by.

Another important issue is the need to provide more basic health units, especially in poor and suburban areas, and to strengthen the existing ones, which are generally open for only a few hours a day and never at night. Professionals, particularly doctors, are notorious for not putting in the full period they are paid for. As a result, people go directly to the emergency departments of public hospitals, where the wait is long but service is guaranteed. Thus, simple problems compete with genuine emergencies for attention.

Within the voluntary contracting subsystem, the relationship between patients and providers has also been contentious, mainly when the services are contracted directly by families and individuals. The lack of regulation has obliged users to complain to the consumer protection service, and health companies are among the services with the most complaints against them.

The complaints are mainly that the companies do not abide by the contracts. They exclude people with certain diseases and elderly people without warning. They deny care, limit the number of hospital stays, charge extra payments, and raise prices. Most companies do not cover preexisting diseases, acquired immune deficiency syndrome (AIDS), cancer, or many complex procedures. It is common practice for these companies to send expensive patients to public hospitals, usually on the referral of doctors who work in both services.

Another issue being discussed within both subsystems, but for different reasons, is the adoption of gate-keeping procedures. In the voluntary contracting subsystem, the main objective is to control the use of services. The associations that represent the companies have already suggested requiring people to enter the system through general practitioners.

In the public contracting subsystem, use is not excessive because access to services is difficult. Gate-keeping mechanisms could decrease the demand on hospitals but, as has been noted, would require a better infrastructure of basic services. Financial initiatives have recently been offered to municipalities to provide incentives for basic care. It will also be necessary to stimulate the training of general practitioners, which has not been a priority in the universities for a long time.

Relationship between population and payers

Difficulties with public services have prompted people to contract with private companies that feature low prices and few guarantees. Our study identified about 100 different health plans in the city of Rio de Janeiro, many of them limited to a single clinic. In suburban areas of large cities, where the poorest population lives, there are clinics that have revived an old practice and offer a "health plan" that covers only office visits, for an amount of, for example BR $10. These small private services are taking advantage of the breakdown in public services, by adopting the strategies of large private companies.

However, the voluntary contracting subsystem is also diversifying and searching for strategies to deal with the low-income, majority of the population. There are, at present, many different health plans, with different lists of services and prices.

Considerable changes are also occurring in the public enterprises that, in the 1980s, began to offer private health plans to their employees as a substitute for self-managed plans. These enterprises have increased employees' financial contributions and, in many cases, introduced co-payments. For a long time, the employees of these enterprises and their dependants had access to the best private providers, and the enterprises provided most of the financing. Plans included mental health and dental care, services that are not offered in regular private plans, except under separate contract, and for which public services are extremely precarious. Employees had free choice of all services with reimbursement based on prices higher than those available from private companies, and had no limits on their use of services. The withdrawal of these special privileges has been followed by an offer of private plans to the majority of public enterprises and offices.

Within the public contracting subsystem, social participation has been strengthened. However, it remains restricted to issues internal to the health sector, mainly management and supervision, even though it is known that many problems, such as low levels of financing, originate outside the health sector in government policies. In contrast to the 1980s, it seems that civil society of the 1990s does not relate problems in the health sector to overall government strategy. In fact, the last two governments have themselves been the main critics of the health system, identifying the problems as inefficiency and improper use of resources.

Considering the popularity of these governments, only interrupted by the impeachment of the previous elected president, and the day-to-day experience of the population with health services, at least it raises doubts about who is responsible. These governments have proposed restructuring the Sistema Único de Saúde (SUS, unified health system) and the universal right to health care; however, the few and timid comments in this direction have not found support and have been criticized even by members of the government itself. This may be why the many groups within SUS that are identified with the principles of the reform continue to protect the system from the strategies being applied by the central government in other areas, mainly privatization. There is an impasse at this point. Even if the government wanted to, it does not have the power to change the framework of SUS. The defenders of SUS, in turn, do not have enough power to improve it.

The impasse will probably be solved within the ongoing process of decentralization, as state and local governments, particularly the latter, begin to flourish as effective intermediaries between the population and the main payer of health — the central government.

Conclusion

Up to now, the reform has succeeded in changing important characteristics of the system that prevailed from the 1970s to the 1980s, but not the segmentation of access to health care, which may be even more complex now.

In the 1970s and 1980s, there were two types of segmentation. One type determined who had the right to be in the system and who had not, because coverage depended on contributing to social security which was only made possible through an official contract of employment. Another kind of segmentation occurred among those who were insured, because there were differences among the lists of services and their quality, according to the positions acquired by the various categories of insured groups.

At present, it may be said that the first distinction no longer exists; the whole population is under the Sistema Único de Saúde (SUS, unified health system). However, the segmentation remains, with more dimensions and with larger distances between the groups.

First, there is segmentation by income. With the breakdown of the public system, anyone who can afford to signs a contract with a voluntary private service. Segmentation occurs within the private system, as the offerings differ enormously from one company to another. Segmentation occurs based on hierarchical position in the formal labour market. Thus, in the same company or sector of the economy, for example, there are different levels of private coverage. Segmentation also occurs in public services, according to the services offered to the population by a given government.

Curiously, none of these services guarantees quality. On the contrary, it may be found in any of them. The exceptions, where quality really is guaranteed, are some private hospitals, some public hospitals owned by states and municipalities, and most of the public hospitals owned by the federal government.

The segmentation results in a number of different combinations of coverage being associated with SUS. Even the groups at the top maintain links with the public system because it is in the public hospitals that the most advanced technology is found and the best professionals are concentrated. Access is guaranteed through doctors, who usually charge for services in their offices, but not for those in the hospital.

This practice, however, is not limited to groups in better positions. Health services reproduce a historical characteristic of Brazilian culture: access to benefits through personal relationships. Thus, for example, it may be as useful to a home-maker to have a neighbour who is a nurse or even a cleaner in an important public hospital, as it is for a senator to have a private doctor who is also the director of that hospital. Gender may make a difference. In the first case, the relationships are mainly established by women, and in the second by men. This may be explained by the fact that in the upper groups personal relationships are established within the public sphere, which is dominated by men, whereas, within in the lower groups, relationships are established in the private sphere, which is dominated by women. But by whatever means the relationships are established, they serve as ways for people to gain access to the hospital's benefits.

It thus seems that Brazilians continue to need more than guarantees by the state or private contracts. Either they do not believe in them, or they have more faith in personal relationships. In any case, they still seem to be insecure about what will happen when they need health care.

Chapter 6.
The Context and Process of Health Care Reform in Mexico

Silvia Tamez and Nancy Molina

Introduction

As in many other Latin American countries, the Mexican Sistema Nacional de Salud (SNS, national health system) has undergone considerable change over the last two decades. The reasons for the change were both internal and external, and mostly of an economic nature.

Beginning in 1981, a free fall in oil prices, the consequent decrease in foreign earnings, and rising interest rates made it impossible for Mexico to continue servicing the national debt. The gravity of the crisis was reflected in a general deterioration in all indicators of economic growth. Since 1995, there has been some improvement in the economy, although the effects of 15 years of continuous economic recession have decisively eroded the "social contract." The social contract arose out of the Mexican Revolution and is considered by many to be the basis of social stability in the country over the last few decades.

Some indicators that illustrate the effect of the crisis on the evolution during the 1980s of social spending in general, and health expenditure in particular, are as follows:

- Between 1980 and 1989, public expenditure decreased from 10.1% to 4.3% of gross national product (GNP) (Valenzuela 1992). The social programs most affected were education and health.
- The relative share of social expenditure, including health, decreased from 2.5% of GNP in 1982 to 1.3% in 1988. Over the same period, the proportion of public health expenditure dropped from 6.2% to 2.5% of total public expenditure (López and Blanco 1993). Indeed, total health expenditure in 1988 was 42% less than what it was in 1982 (Valdés 1991).
- Real salaries dropped by more than half in between 1982 and 1990, comparable to 1962 levels, and their share of GNP fell from 37.5% to 24.0% (Valenzuela 1992).
- During the same period, formal employment decreased from 92% to 74% of the total workforce, whereas the informal sector grew from an insignificant 1% to 14% (López and Blanco 1993).

The economic crisis gradually gave way to a political one. Protests against the drop in real wages exceeded the limits of negotiation. In 1983 alone, there were 3 000 strikes, more in one year than during the whole previous 6-year administration (Frenk et al. 1994). The government refused to change its policy on wages, however, and this alienated some sectors of the economy. Several attempts to increase benefits, including health care coverage, proved fruitless as the crisis deepened and the international creditors started putting pressure on the government to reduce unemployment and welfare benefits. The failure of the state to honour its obligations and the relative expansion of the informal sector reduced the government's credibility and hence its legitimacy. Since the early 1990s, there has been a profound questioning of the corporate pact between the state and various interest groups. The economic and social reforms that are now taking place, including health care reform, thus form an integral part of the process of redefining the roles and responsibilities of the state and the citizens and their representatives.

While political and economic changes have been the most compelling reasons for reforming the health sector, one cannot discount the impact of the profound epidemiological and demographic transition that Mexico has undergone in the last few decades, nor the growing recognition of the need to improve equity and quality in health care.

While there is general agreement on the reasons for health reform, there is less of a consensus on what the reform means and when it actually began. For the purposes of this study, we have identified two key periods that may be considered as the precursors of health care reform in Mexico. The first began in 1983 with the proposed additions and amendments to Article 4 of the Constitution that effectively raised the right to health protection to the constitutional level. The second period began in 1995 with modifications to the Ley del Seguro Social (social security law) and the adoption of the Programa de Reforma del Sector Salud 1995-2000 (PRSS, health sector reform program 1995-2000) (Aboites 1997).

The reform proposed in 1983 intended to radically transform the health care services and clearly establish the strategies to do this. Its success was limited, however, by resistance on the part of various interested parties, as well as a lack of citizen participation. On the other hand, the changes initiated in 1994 originated within a context of changing political process (Fleury 1990) and occurred in response to pressure from various interest groups. These changes aimed to produce a profound transformation in the health care services and involved modifying the regulatory framework that governed them. The involvement of different interest groups and their diverging political agendas in the process has generated contradictions and tensions, however. The way in which these are reconciled will affect the future direction of reform.

Background Influences

Antecedents Shaping the Health Care System

The role of the state and its institutions in guaranteeing social rights is enshrined in the Constitution of 1917. But, although Article 3 on the right to education and Article 123 on labour relations apply to the entire population, access to social benefits depends to a large extent on an individual's place in the labour market. This is particularly so in the case of access to health care services, because the population is divided into two groups: those who are insured by virtue of being employed in the formal sector, and those who are not insured because they are self-employed or work in the informal sector. The origin of this situation goes back to 1950s when the foundations of the privileges accorded to the most powerful groups, such as the military, the public service and some sectors of the working class, were laid (Fleury 1990).

Health care policy from 1917 up until the end of the 1970s can generally be considered to have responded to the needs of the "corporate pact." Under this pact, the institutional mechanisms for providing social benefits served as an efficient means to channel the demands of certain sections of the workforce, but at the same time, to co-opt them for the government's purposes. The result of this process was the appearance and consolidation of a fragmented public assistance system that failed to cover the entire population. It did, however, improve the lives of some workers and of other segments of the population, as coverage by the social security system grew at a yearly rate of 10% between 1960 and 1970 (Laurell 1996).

Structure of the Health Care System

At present, the compulsory social security system covers little over 50% of the population (Secretaría de Salubridad y Asistencia 1996) and includes formally employed workers, members of production cooperatives, and various organized groups of small landowners and agricultural workers.

The rest of the population that is not covered by social security is covered by the Secretaría de Salubridad y Asistencia (SSA, department of health). This population is a complete mosaic, because it includes people from all strata of society, from the wealthiest self-employed professionals to the poorest rural workers and indigenous groups. None of the following are included in the social security system: people who work in family businesses; self-employed professionals, craftsmen, and traders; small landowners and agricultural workers who are not organized into associations or credit unions; and individuals (not businesses) who employ insured workers. These people have the option of voluntarily insuring with the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), but the cost and requirements for doing so, as well as the lack of publicity concerning this option, have made it an insignificant one.

Private health care provision has developed at the fringe of official policies, and now accounts for 50% of total expenditure on health. The private sector owns about 30% of hospital beds, employs 34% of doctors, and provides about 32% of medical consultations. Private medical care is very important among those with the fewest resources, covering up to 41% of all contacts with doctors. Private medical insurance coverage, however, is very limited (2%) and the use of managed insurance schemes is even more so (Secretaría de Salubridad y Asistencia 1996). In spite of this wide range of services, there are still about 10 million inhabitants in the country without access of any kind to formal health care services.

Because of this, some authors have classified the Mexican health care system as a "segmented model," and they consider its structure according to two fundamental dimensions — social groups and functions (Frenk et al. 1994). With respect to social groups, there is a clear distinction between the poor and those able to pay. The paying group can be subdivided again into formal sector workers and their families, and the self-employed, mostly urban middle- and upper-class people who are not covered by social security. The latter are usually attended to by the private sector through out-of-pocket payments or prepayment schemes, which are being used increasingly in the voluntary contract system. Finally, there are the poor, both rural and urban, who are excluded from social security because they do not work within the formal economy (Londoño and Frenk 1997).

The main problem in analyzing the health care system by function is that the different social groups are segregated into separate subsystems. The present system can be characterized as being "vertically integrated" but "horizontally segregated" (Frenk et al. 1994). This means that each institutional group (social security, public sector, or private sector) functions separately. The SSA is responsible for the administration of personal health care services for the poor.

Many problems arise from this structure, among which are duplication of effort, waste of resources, and the creation of monopolies serving different sections of the population. Perhaps the most serious problem is the overlap in demand, because a high proportion of those who are covered by social security also use private sector services or those of the SSA. In these cases, the patient pays twice or even three times, a situation that has been described as multiple contribution. Despite many and repeated efforts to encourage decentralization, the system still suffers from the inertia generated by many years of centralization.

In short, the health care system features incomplete coverage, stratification by population group, and excessive centralization, as well as serious problems of duplication, poor quality, and inefficiency. These issues have been used from the beginning of the 1980s in official arguments to justify the need for health sector reform, and they are still being used today.

Reform Process

As was stated in the introduction, to understand the process of reform of the health care services in Mexico, two periods must be analyzed. The first is the period from 1982 to 1988, when the "structural change" that laid the foundation for the subsequent transformation of the health care system was made. The second period covers the changes that have been underway since 1995 and were expressed in the modifications to the Ley del Seguro Social (Social Security Law) and in the points contained in Programa de Reforma del Sector Salud 1995-2000 (PRSS, health sector reform program 1995-2000).

Structural change — 1982-88

Formulation of the proposal for reform

During the 1980s, Mexico went through an economic crisis that made adopting structural adjustment measures imperative. These included reducing public expenditures by streamlining public institutions. In 1981, the Coordinación de los Servicios de Salud (health care services coordination) was created on the initiative of the President of the Republic, with the aim of studying the possibility of integrating the various institutions into a single, national, health care system. For the first time, a team of specialists was asked to propose policies that would lead to the unification of all public health care institutions, with a view to providing more efficient, accessible, and better quality services.

The reform that began in 1983 with the modification of Article 4 of the Constitution sought to respond to these goals through a complete overhaul of the administration of health care services, in what was known as the "structural change."

In formal terms, the reform was sustained by its intention to create the Sistema Nacional de Salud (SNS, national health system). The strategies that were defined for the consolidation of the system were decentralization, administrative modernization, coordination between the different sectors, and community participation. Decentralization was the most important of these strategies.

The creation of different sectors involved establishing the means for determining population groups and designating coordinating entities within each sector. It also regulated the organization, function, and control of state-supported entities and the coordination of others under an arm of the Federal Executive.

The decentralization of health care services was gradual and began in 1984 with the first of two stages: the coordination of programs (1983-84) and the integration of organizations (1985-86). Under this strategy, services were financed by re-ordering federal and state resources and diversifying sources of funding.

Administrative modernization was based on a dynamic reorganization of the system and the institutions that make it up, with a view to making the SNS function better. The process of modernization was carried by the Secretaría de Salubridad y Asistencia (SSA, department of health) in its role as regulator and supervisor of the system.

Coordination between sectors was promoted on the assumption that health care problems arise not only within the different sectors but also between and among sectors. Entities such as the Gabinete de Salud (health cabinet) and the Consejo de Salubridad General (general health council) promoted various coordination initiatives, both at a sector and institutional level.

Community participation was encouraged through several legal instruments that were put in place for interventions in areas such as health promotion, health education, better health care services utilization, and maternal and child health.

Another important modification precisely defined the method of coordination within the sector. The SSA was responsible for coordinating federal health care institutions, including the programs and functions of the social security institutions. This modification also gave the SSA the power to intervene in the planning and budgeting processes of each institution.

According to the Ley de Planeación (planning law), planning would be the ideal instrument for making the SNS effective. This law envisaged the existence of a health sector program to which all institutional programs would be subject. This federal program would cover the whole country, taking in the three levels of government as well as the social and private sectors, and using obligation, coordination, incentives, and harmonization to achieve its ends.

Both the design and implementation of the reform proposals were carried out by the government and the SSA alone. Only afterwards were the public institutions that would be affected by the changes, and the representatives of employers and workers involved, called in. The success of the proposals depended on the support of all the institutions involved, but especially the Instituto Mexicano del Seguro Social (IMSS, Mexican social security institute), which had, since the 1970s, become the most powerful institution of the health sector.

Politically, the reform implied a change in the balance of power between the different institutions, putting the SSA on top, and for this reason it faced serious resistance. Thus, "the corporations that could see their exclusive access to goods and services threatened, along with their share of power, formed, under the leadership of the IMSS, followed by the organized labour movement, a vetoing coalition" (González et al. 1995).

Legal framework — Article 4 of the Constitution and the Ley General de Salud

This section is based on Valdez (1988). Without doubt, the most important legal advance in the area of health care was the inclusion in Article 4 of the Constitution (3 February 1983) of the social guarantee to the right to health protection. This constitutional guarantee established that every person has the right to health protection; the law will define the basis for and methods of accessing health care services; and the same law will establish the role of the federation and federal entities in the health care sector.

Unlike individual rights, which must only be respected by the state, the right to health protection was a social guarantee, like those already established in the areas of education, work, housing, and family planning. This means that the state is responsible for doing whatever is required to see that this right is satisfied.

This right has three characteristics. It is universal and without limits, being accorded to all citizens by virtue of being Mexican. It guarantees access to health care service and will define in law the basis for and methods of obtaining such access. It establishes the way in which the federal government and the states will carry out the decentralization of health care services, with the consequent strengthening of this constitutional right.

Congress approved the Ley General de Salud (general health law) in December 1983, it was published on 7 February 1984, and came into force on the first of July of the same year. This law included additions and amendments to Article 4 of the Constitution with a view to defining the contents and the intentions of the right to health protection; establishing the legal basis that would make that right effective; defining the role and responsibilities of the public, social, and private sectors; establishing an operational basis for the Sistema Nacional de Salud (SNS, national health system); defining the regulations for the provision of services; updating and completing the principles of general health; and delineating the jurisdiction between the various health care authorities.

This legal document was the first attempt to regulate service functions within the health sector under the guidance of a coordinating body, the Secretaría de Salubridad y Asistencia (SSA, department of health).

Sistema Nacional de Salud

Based on the two items of legislation described above, as well as the Ley de Planeación (planning law) of December 1982, which laid the foundation for decentralization, the Sistema Nacional de Salud (SNS, national health system) attempted to implement the right to health by harmonizing federal and state programs and the social security and private sectors.

The objectives and components of the SNS were defined with the explicit purpose of extending coverage to the whole population, giving priority to the least protected, and improving the quality of the services provided. The task of coordination was left to the Secretaría de Salubridad y Asistencia (SSA, department of health).

The most important strategies for consolidation were:

- **The creation of sectors** was based on the Ley Orgánica de la Administración Pública Federal (federal public administration organization law), 29 December 1982, which grouped all kinds of institutions in the health care sector by programs, functions, and services, and the Ley Federal de Entidades Paraestatales (federal law on state-owned enterprises), of 14 May 1986.
- **Decentralization of health care services for the general population** began with a decree published on 8 March 1984, and was based on a model of gradual decentralization.
- Administrative modernization and coordination between sectors.
- **Community participation** was based on the reform of Article 26 of the Constitution and Articles 7, 10, 13, 57, 58, 59, and 60 of the Ley General de Salud (General Health Law) and several other dispositions.

Implementation of the reform

Administrative modernization of the Sistema Nacional de Salud (SNS, national health system) was achieved in three stages. The first (1982-83) consisted of restructuring the offices of the Secretaría de Salubridad y Asistencia (SSA, department of health), which were top heavy. The second (1983-84) concentrated on organizing the decentralized administrative units by territory. And, the third (1984) attempted to restructure health care services to achieve integrated organizations and functions across the systems of epidemiological surveillance, medical care, and social assistance.

The process of decentralization, one of the main strategies of the reform project, varied in its development from state to state. Official accounts reported positive results in terms of services provided and potential coverage. Nevertheless, only 14 states achieved decentralization and the success of the process depended to a large extent on the economic situation of the state involved. Thus, in the poor states, health care services deteriorated when the federal subsidy was reduced.

With respect to community participation, official sources report the establishment of health care programs in all states, 11 000 health care committees nation-wide, and training activities for 100 000 voluntary health promoters.

Some of the objectives of the SNS were seriously compromised by reduced health care spending. Among these were extending health care coverage to the most unprotected groups; promoting programs to develop infrastructure; and improving the quality of health care services.

During the period 1988-1994, most of the activities undertaken by the previous presidential administration were suspended. The new government put the emphasis on modernizing government departments, favoring social policies featuring high levels of specialization, increased centralization, and harmonization of institutional resources.

Although the SNS retained the features previously specified, some changes were made that affected the lines along which it would develop. The decentralization program was suspended and, in its place, selective programs were introduced that targeted the poorest population groups. Under the aegis of the signing of the North American Free Trade Agreement (NAFTA), regulations were modified to allow international companies to participate in private insurance, which resulted in a considerable increase in prepaid medical insurance (Tamez et al. 1995). Moreover, the growth of an industrial medical complex, based on high technology, service networks, and the consumption of pharmaceuticals, was favoured through economic and legal incentives (Laurell and Ortega 1991).

It was also during this period that one of the most important changes was made, which was to pave the way for a subsequent proposal for the reform of social security. This change was the creation of the Sistema de Ahorro para el Retiro (SAR, savings for retirement system), by which collective funds were replaced with individual ones, and the administration of these funds was transferred from the public sector to private banks.

Evaluation

The evolution of health care financing is fundamental to an evaluation of the process of reform during this period. It helps explain the change of direction in social and health care policy, and to highlight some of its many inconsistencies. During the 1980s, there occurred a continued contraction of public and social expenditure; a financial restructuring of public institutions, with the disappearance of or reduction in subsidies; inconsistencies in reducing expenditure between the various subsectors, which exaggerated inequality of access and kept uninsured groups at a disadvantage; and an imbalance in the distribution of expenditure between different programs, resulting in increased expenditure on treatment and decreased expenditure on prevention.

The policy of reducing public expenditure while attempting to extend coverage caused financial problems that resulted in a gradual deterioration in public services, which in turn was used to justify further and more profound modifications to the Sistema Nacional de Salud (SNS, national health system). One indirect effect of the decline of the public and social security subsectors, intended or not by the reform, was the growth of the private subsector. This was manifested in the proliferation of private, prepaid, medical insurance and an increase in the practice of subcontracting public medical services to the private sector.

Because the changes undertaken during this period were proposed by the state and based on the results of negotiations between government representatives, employers, and labour organizations, they were unsuccessful, and the Secretaría de Salubridad y Asistencia (SSA, department of health) was unable to fulfill its coordinating role. The terms of the reform apparently undermined the basis of the corporate pact. The organized labour movement, under the leadership of the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), felt its interests threatened and obstructed the proposed changes (Martínez 1997). This was made possible due to the lack of participation by the civilian population and other groups affected by the reform.

During the period 1988-1994, the excessive centralization and fragmentation of the public health care subsystem led to duplication of effort, poor coordination, and lack of control, which reduced its efficiency and effectiveness. The strategy of focusing selectively was clearly expressed in the Programa Nacional de Solidaridad (PRONASOL, national solidarity program), which was directed at the poorest population groups, especially those in rural areas. It was a kind of substitute for the process of decentralization begun by the previous administration. The discretionary manner in which the budget was allocated, however, was seen as clearly political, a means for enhancing the credibility of the government.

PRONASOL also corresponded to a new social policy strategy that arose as it became evident that the existing system of alliances between the government and interest groups was failing. Old favorites, some social organizations and unions were abandoned and an attempt was made to reach out to groups that had been demanding inclusion in the arrangement. Thus PRONASOL attempted to reach different population groups, providing public goods and services in exchange for political support.

It was also during this period that the public recognized the need to modify the social security system, due to deterioration of services and financial problems in the institutions involved. PRONASOL also took over the structure of the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security)'s Coordinación General del Plan Nacional de Zonas Deprimadas y Grupos Marginados, (COPLAMAR, national program for depressed areas and marginal groups), which kept its government subsidy but changed its name to IMSS-Solidaridad (IMSS solidarity) (González et al. 1995).

Total reform — 1995-1997

A new cycle of changes, directed at reforming the Sistema Nacional de Salud (SNS, national health system), began in 1995. Because the changes that have been approved only came into force a few months ago, this section will focus on the on development of the reform rather than its effects. In the section on implementation, some points of view as to the tendencies observed will be presented by way of conclusions.

Formulation of the new basis for reform

From 1994 to the present, the state has been actively participating in changes to the health care sector. In 1995, President Ernesto Zedillo set out the objectives of the proposed health care reform for discussion in the national development plan (Secretaría de Hacienda y Crédito Público 1995). This document describes the Sistema Nacional de Salud (SNS, national health system) as increasingly expensive and difficult to operate because of its segmentation, centralization, poor coordination, and unclear assignment of responsibility. As an answer to these problems, it was proposed to diversify health care services and financing schemes. The changes are aimed at allowing the user some choice of health care provider and opening up the medical service market. The official document also recognized the need to radically change the financing of retirement pensions by the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), on the basis of the Sistema de Ahorro para el Retiro, (SAR, savings for retirement system) created in 1992.

From the government point of view, the health care institutions — IMSS, the Secretaría de Salubridad y Asistencia (SSA, department of health), and the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants) — should play a fundamental role in directing and implementing the changes. The Secretaría de Hacienda y Crédito Público (SHCP, department of inland revenue) is also considered to play a key role, by virtue of being instrumental in the creation of SAR.

Two closely related projects came out of these initiatives, reflecting the fact that the segmentation of the health care sector is so marked that it will require two simultaneous reform processes: one to deal with the social security system and the other to deal with public health care services for the general population. These set out the lines along which health care policy is to develop.

The Programa de Reforma del Sector Salud 1995-2000 (PRSS, health sector reform program 1995-2000), although it touches on the general aspects of the system, is specifically concerned with changes that will affect the uninsured population. According to PRSS' diagnosis, the main problems associated with the current the health care system are poor quality, limited efficiency, segmentation of the population, little coordination, excessive centralization, and insufficient coverage. The proposed changes include decentralization of public health care resources, municipal participation, extension of coverage through a basic health care package, a reorganized structure, and the introduction of mechanisms to increase the quality and efficiency of services.

Federal resources intended for the public health care system will be chaneled through the SSA and IMSS-Solidaridad (IMSS solidarity) in coordination with state health care programs. The intention in the medium term is to concentrate state-level public health care services in the areas of greatest poverty, both rural and urban, and thereby avoid duplication.

Municipalities will participate in health care through the program, *Municipio Saludable* (Healthy Municipalities). This program involves community participation in the definition of priorities and the design and evaluation of local health care programs.

Extension of coverage will be achieved by means of a basic package of services defined as "... the minimum number of health interventions that must be provided to any population with respect to priority needs (risk factors, injuries and sickness)" (Secretaría de Salubridad y Asistencia 1996). The package will include 12 kinds of public health and health promotion interventions that are easy to implement at low cost and with high impact. This package is to be applied in 380 extremely poor municipalities in 11 states of the Republic, where there are 4 million inhabitants, 30% of whom have no access to any regular source of medical attention.

A new model of health care system is to be created out of the old one, which divided the population into four groups: those with access to private insurance; those with access to social security; those with access to SSA and IMSS-Solidaridad; and those with no access to any such services. The new model will divide the population into three groups: those with private insurance, including new forms of insurance plans; those with extended social security; and those with access to state-level public health care systems comprising services from the SSA and IMSS-Solidaridad. The last is expected to extend coverage to the 10 million people currently without it. Under the new model, the SSA will take on the regulating and standard-setting role for the health care sector.

From the government's standpoint, integrating and decentralizing the public health care services and extending these services through a basic package will promote greater efficiency and a specific focus on efforts aimed at reducing poverty. Also, the separation between formal and informal workers will be less marked.

And finally, the reform calls for the promotion of mechanisms that result in increased quality, efficiency, and cost-containment and the introduction of a system of incentives based on user choice. These mechanisms will be incorporated into urban social security services in particular, where the segment of the population with the most supply options is located. Unfortunately, however, the introduction of user choice threatens the unified character of social security. This is because the mechanism will allow the low-risk, high-contributing population to transfer to private insurance plans, while the high-risk, low-contributing population remains with the public institutions.

Social security reform

During 1995-1996, officials within the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) analyzed their situation and became the main promoters of social security reform. The reasons given for the need for reform were the aging of the population, the increase in chronic, degenerative disease, and the impossibility of raising contributions. Particular emphasis was placed on the aging of the population, as retirement was the main cause of the drop in contributions (IMSS 1995).

Another factor behind the IMSS' reform proposal was that the way the system was financed was said to discourage job and salary growth. Employers and workers were accused of using sophisticated practices to evade payment of contributions. Also, the excessive number of IMSS employees and their burdensome collective agreement was blamed for much of the institution's financial trouble (IMSS 1995).

Certain unshakable tenets of the social security system were questioned in the document, *Diagnóstico: los propósitos más generales de la reforma del IMSS* (diagnosis and proposal for the reform of the IMSS), which advocated such things as improving equity and quality of service, freedom of choice of provider, and incentives for increasing employee productivity. The reform proposal is based on three objectives: making the institution, and particularly services such as sickness and maternity insurance, financially viable; extending social security coverage to workers from the informal sector through "family health insurance"; and improving the quality of services.

IMSS officials believed that the following changes were needed to bring about these objectives: a separation between the financing and provision functions in the insurance plans offered by the institution; an increased state subsidy; and the incorporation of workers from the informal economy. With respect to disability, old age, retirement, and life insurance, the proposal was to link contributions with pension benefits by means of compulsory pension plans funded by private capital.

The proposal for sickness and maternity insurance was to create a single, uniform, indexed contribution that would not be proportional to wages. Those insured whose basic wage was more than three times the minimum wage would pay an additional amount. Moreover, both workers' and employers' shares would be reduced by 33%, which instead would be covered by the state. This means that the state will contribute seven times more than under the previous scheme.

The point that caused the most conflict was a change to the return-of-contributions scheme that will allow employers to reclaim up to 40% of sickness insurance contributions as long as they can show that they will provide the service adequately outside the IMSS. It is interesting to note that the amount returned will include part of the government's contribution. Thus, the private sector will receive a kind of subsidy from the public sector, because it is expected that many of the organizations contracted to provide services will be private. Although, in the end, this change was not approved, the system already established by law is expected to be modified along the same lines.

Contrary to the changes carried out a decade ago, the more recent reform process has been the subject of debate among several of the affected groups. The most important organizations of employers took part in the debate, putting forward their proposals. These organizations basically agreed with the reform plan, although they diverged on the way specific reforms should be implemented. They concurred on the need to separate the different branches of insurance, both functionally and financially, and to completely restructure them, introducing a public-private mix into the system. They placed great importance on promoting the private sector's participation in the financial management of health care funds and in the provision of services by means of return-of-contribution agreements. They shared the conviction that IMSS must be entirely restructured and that all social security institutions should be united into a single body with one set of guidelines for costs and benefits, and a single collective agreement. On the specific points about the different insurance plans, the employers generally agreed with the proposal put forward by IMSS.

On the other hand, in 1994, the Fundación Mexicana para la Salud (FUNSALUD, the Mexican foundation for health), which is considered to be a group of experts with a real capacity to influence official opinion, presented a restructuring plan for the entire health care sector. The plan was based on a full and detailed analysis of health care services, as well as the epidemiological situation, in the country. It showed the epidemiological profile to be one of polarized morbidity-mortality in a state of transition. It characterized the existing health care as unsafe, inequitable, insufficient, inefficient, poor quality, and over-priced (Frenk et al. 1994).

FUNSALUD advocated the creation of a universal, decentralized health care system that would be organized on the basis of functions and not population groups. The financial part would be the responsibility of the Fondo Nacional de Salud (national health fund), which would in turn be funded out of general taxation. One health insurance system would exist with two forms: the Paquete de Servicios Integrales (complete services package) for wage-earners and the Seguro de Salud Nacional (national health insurance) for others, with individual premiums and a state subsidy for the population with access to the Paquete Universal de Servicios Esenciales (universal package of essential services). The proposal involved several different kinds of management to diversify service provision through public or private organizations, with differences between institutions providing services in rural areas and those in urban areas.

The government's vision of health reform has been countered by various other proposals for solving the problems of the Mexican Sistema Nacional de Salud (SNS, national health system), in what might be called a "line of opposition" to the official bloc. This line of opposition includes several different organizations, such as pensioners' groups, the IMSS trade union, and the Partido de la Revolución Democrática (PRD, democratic revolution party).

The opposition sees the deterioration of health care institutions as the result of depressed wages, job stagnation, and cutbacks in social expenditure, factors which are also responsible for the under-financing of social security institutions. In the opposition's view, health care expenditure must be increased and stabilized, with a target level of 8% of gross national product (GNP). As a means to bring about universal coverage, a Servicio Único de Salud (single health care service) by the Secretaría de Salubridad y Asistencia (SSA, department of health) is advocated. A proposal by the PRD would have a department of health and social security responsible for preparing a technical proposal for the unification of health care services (Laurell 1996). The system would function on four levels — national, state, local or municipal, and institutional — in the workplace to favour a democratic approach to implementing health care policy. Under the *Servicio Único de Salud* scheme, decentralization would encourage the development of technical, decision-making, and financial capacity at the state and municipal levels.

Before the changes to the law governing the IMSS, were approved, proposals regarding social security focused on recovering growth in affiliation by at least 5% per year; raising the ceiling on contributions (the present limits reduce the institution's income and restrict the unifying and leveling nature of social security); and increasing state participation to historically maximum levels.

These proposals were based on financial analyses that showed that the content of the new law governing the IMSS would not solve the institution's financial crisis. It would encourage low-risk, high-contributing workers — the 30% who earn more than three times the minimum wage and therefore pay an additional amount — to take advantage of the return-of-contribution scheme. This would lead to a 50% reduction in the IMSS' income with 70% of mainly high-risk, low-contributing patients still to be attended to (Barreiro 1997).

Some of the parties who should have taken an active part in the debate on the reform of health care services and social security did not. These parties include the Central de Trabajadores de México (CTM, Mexican workers central organization) and the Congreso de Trabajo (trade union congress), as well as the owners of the big hospitals and the professional associations.

Despite indications of rejection on the part of various sectors, especially IMSS employees, the initiative was approved in December 1995. It was supposed to take effect in January 1997, but was postponed to July of the same year because there were apparently serious obstacles to its implementation. The most serious of these was a shortfall in the government budget, making it unable to cover the subsidy it had committed itself to. The additions and modifications to the law governing the IMSS finally went into effect in July 1997.

The legal framework

The Ley del Seguro Social (social security law) of 1943 was inspired by a concept of social justice and a notion of the welfare state predominant at the time. The law was based on solidarity, state-subsidization, equality, immediacy, inalienability, and the participation of those concerned, and it tended toward universality and integration of social services (health, retirement, workers' compensation, etc.). In general terms, the concept of Mexican social security was based on the principle of solidarity.

The changes approved in 1995 broke with these fundamental principles. What had been a social security system became a financial mechanism for helping the economic growth of the country (De Buen 1996). Among the important changes in this respect are those relating to pensions and medical services.

In the area of pensions, Articles 167 to 200 of the new law establish individual accounts, thus removing the basic principle of solidarity from the system. For medical services, the way was opened for subcontracting under the return-of-contributions option. These changes also affect the principles of equality, universality, integrity, unity of management, and participation of interested parties, on which the old law was based.

In addition to this, the new law affects such workers' rights as the amount of basic and disability pensions. It limits the right to contest decisions regarding sickness or work-related accidents. It introduces disadvantageous mechanisms for revising pension amounts, resulting in an increase in the number of years of contributions required to qualify for old age or disability pensions, and leading to a notable loss of buying power (Saenz 1996).

De Buen (1996) summarized the situation by stating that the new law changed

> ...the common and redistributing spirit of the system for a new financial structure of an eminently individualistic character, in which the benefits that may be received will be directly related to income and workers', employers' and government contributions,

> that is to say those who earn more will receive more benefits than those who earn and contribute less, forgetting that without solidarity there is no social security.

Conclusions

The process of reforming the Sistema Nacional de Salud (SNS, national health system) may be considered to include changes set in motion during two periods, the beginning of the 1980s and the middle of the 1990s. To differing degrees, both periods occurred in a context of economic crisis and of a questioning of the social contract that had been the mainstay of political stability in the country for decades.

The current chronic situation of economic and political crisis demands a profound transformation of the relationship between state and society, and it is said that the country is in a period of democratic transition. The reform of the Sistema Nacional de Salud (SNS, national health system) is part of this process.

The SNS since the 1970s may be described as a "segmented model," as it divides the population into two major groups, the insured and the uninsured. It also segregates the population functionally, because each institutional group carries out its functions separately. These aspects have led to the sector being characterized as stratified by population group, centralized, and with problems of coverage, duplication, and quality.

In the process known as the "structural change," the reform was fundamentally proposed and carried out by the federal government, which assigned the role of directing and regulating to the Secretaría de Salubridad y Asistencia (SSA, department of health). Its purpose was to create a national health system that would coordinate all health care institutions under the supervision of the SSA. Although the reform was based on clear principles and goals, its success was limited because of the situation of economic austerity and resistance to the changes by some powerful interest groups that formed part of the corporate pact. As a result, coordination between the different institutions, which was considered to be one of the most important goals of the reform, was not achieved.

Some of the things that were achieved during this period were as follows: the right to health protection was enshrined in the Constitution; the right was reinforced in the *Ley General de Salud* (general health law), which laid out the specific standards and regulations for its expression; and decentralization of public health care services was implemented in 14 states of the country.

The success of these changes was limited, however, because most of the actions related to them were suspended during the following presidential term. This period was characterized by a high degree of centralization, an absence of control, an increase in duplication of effort, and a lack of coordination with respect to the health care system. In place of decentralization, selective programs were set up for the poorest population groups, as a means of increasing the government's credibility. At the same time, measures were introduced that encouraged the participation of the private sector in the provision of services.

The reform arising from the changes of 1995 can be placed in a context of chronic economic crisis and changing political process, within what has been called the "democratic transition." Starting from a very energetic government initiative, drafting the reform depended fundamentally on the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) and the SSA, with the IMSS playing the most important part. Unlike the changes of the previous decade, which dealt mainly with providing services to the uninsured, the latest modifications aim to change the basis of social security.

Nevertheless, two projects clearly express the objectives of the changes, each being directed at a different population group. The first, the Programa de Reforma del Sector Salud 1995-2000 (PRSS, health sector reform program 1995-2000), involves the SSA and affects the uninsured population. The second arises from modifications to the law governing the IMSS, and affects the insured population. Some of the main tendencies in the implementation of the reform are given in the following paragraphs.

Reorganization of the system is based on the socioeconomic characteristics of the population, making it a model whereby access is stratified by income and place of residence. This aspect, added to the fact that the diversification of options is achieved only by creating new kinds of private insurance, will lead to greater inequity of access to health care services. Selecting a doctor will not be a question of choice, nor of need, but only of economic ability, which will or will not allow access to certain services, depending on the purchasing power of each individual (Barreiro 1996).

Because of the historical segmentation of institutions in the sector, we are in practice faced with two reforms: the reform of social security and the reform of the institutions for the uninsured population. In this situation, it will not be easy for the SSA to regulate, because the changes brought in do not solve the problem referred to at the beginning of this section, whereby the two subsystems function independently with respect to financing, provision, and regulation.

The regulatory bodies will also have to face the problem of an expanding and diversifying private insurance sector and the formalization of options involving a public-private mix. Mexico has almost no experience in this area. Furthermore, although more information is available to the population now than ever before, it is still not enough to avoid an unequal relationship between providers and patients. Although an official arbitration entity has recently been set up to deal with cases of abuse and malpractice, there is at present insufficient regulation in this area to ensure its effectiveness.

The social security institutions will have to overcome serious obstacles if they are to compete with private insurers. At present, leaving aside the official version, there are serious doubts as to whether the measures taken will solve the financial crisis in social security. On the contrary, greater under-financing can be foreseen as a result of the return-of-contributions scheme. As has been noted earlier, the IMSS stands to have its income halved. Furthermore, the funds destined for these institutions will now depend not on compulsory contributions but on the government's ability to levy taxes efficiently. It has been calculated that social security reform will cost the federal budget the equivalent of 1.5% of the gross national product (GNP) (Barreiro 1996). It should be noted, however, that a heated discussion is underway between opposition parties and the Partido Revolucionario Institucional (PRI, institutional revolutionary party) in the chamber of deputies on the percentage of taxes to be levied, and there is a great deal of pressure to reduce taxes on several basic commodities.

The tax-raising crisis has cast serious doubts on the success of decentralization as a way of redistributing the federal budget. Also, the speed with which decentralization is advancing (16 states have been decentralized in less than one year) raises the question of whether its democratizing effects will become a reality in the near future.

Unlike the reforms of the 1980s, the present one has been the subject of organized opposition and serious debate. Some of the parties involved, such as the organized labour movement, have lost their power with the weakening of the corporate pact, while employers and financial groups have gained a more powerful position. In the context of changing relationships between state and society, a new social pact must be developed and new parties have arisen that are demanding an inclusive policy of social welfare.

In this respect, while some facts are irreversible, such as the approval and implementation of the changes to the law governing the IMSS, the present advance of democratic forces leaves room for the possibility of a more balanced solution to inequity of access to health care services.

Chapter 7.
Reorganizing the Health Care System in Mexico

Silvia Tamez and Nancy Molina

Introduction

This chapter will analyze the Mexican Sistema Nacional de Salud (SNS, national health system) in two parts. The first will examine the socioeconomic and epidemiological characteristics of the population and the structure of health care services, with relation to expenditure, coverage, organization, and provision. The second will analyze the subsystems of the health care services, using the methodology proposed by the Organisation for Economic Co-operation and Development (OECD 1995). The section will look at the way the health care services have been modified since the beginning of the 1980s and discuss the tendencies within the system since 1995.

Structural Features

Social, demographic, and epidemiological aspects

According to the 1990 census, Mexico has a population of 81.25 million. The territorial distribution (Table 1) shows that the population is concentrated in a small number of cities and metropolitan centres.

In 1990, about 47 million Mexicans were living in cities of 15 000 or more. Of these, almost half lived in the four largest metropolitan areas: Mexico City, Guadalajara, Monterrey, and Puebla. In contrast to this urban concentration,

Table 1. Socioeconomic index, Mexico, 1970, 1980, and 1990.

	1970	1980	1990
Population (thousands)*	48 225	69 655	81 250
Urbanization rate*	57.8	66.3	71.3
Literacy rate*	76.3	83	87.4
Per-capita GNP (US dollars)**	730	2 758	2 868
Life expectancy at birth**	62.21	66.22	69.69
Infant morality rate (per 1 000 live births)**	68.45	38.82	23.95
Mortality rate (per 1 000 inhabitants)**	10.07	6.24	5.21
Birth rate (live births per 1 000 inhabitants)**	44.23	34.85	33.71
Fertility rate***	7.0	4.5	3.4

Sources: *INEGI (1992). **Presidencia de la República Mexicana (1993). ***FUNSALUD (1994).

the remaining population is greatly dispersed, living in thousands of small rural centres. In 1990, about 28 million Mexicans lived in more than 155 000 small outlying towns or villages of fewer than 5 000 inhabitants (Secretaría de Hacienda y Crédito Público 1995).

There is a downward tendency in the growth rate of the population. Between 1930 and 1958, the annual growth rate was 2.5%, which resulted in a doubling of the population over this period. Between 1960 and 1970, the annual growth rate was 3.2% but it decreased to 2.3% between 1980 and 1990. The growth rate for 1992 was estimated at only 1.9%. Although the increase in population has slowed, there is still a significant increase in absolute numbers, and the most recent figure places the population at more than 90 million.

In general, the population of the country is young. An "aging" process can now be observed, however, as the proportion of the population below the age of 15 falls and the proportion of adults rises correspondingly. For those aged 65 and over, the proportional increase is most notable, with an annual growth rate of 3.8%. In 1994, the population distribution was: 57.87% below the age of 25; 36.02% between the ages of 25 and 59; and 6.09% aged 60 or more (Secretaría de Salubridad y Asistencia 1994a).

Fertility rates and death rates are closely related to the demographic changes in the country. In the case of fertility, it was not until 1970 that any reduction occurred at all. Between 1930 and 1950, there was a stable overall fertility rate of 6.5 children per woman. From 1950 to 1970, there was a slight increase, to 7 children per woman. From then on, the rate began to decline, to 4.5 children per woman by 1980 and to 3.4 children in 1990. There is an observable difference, however, by region and by poverty level of the mother, with the poorest states presenting fertility rates well above the national average. In 1990, for example, the overall fertility rate in states such as Chiapas or Oaxaca was more than 4.5 children per woman, whereas in the Federal District of Mexico City and other states of the central region, it was less than 2.4 (Frenk et al. 1994).

There has been a notable decline in death rates during this century. Between 1940 and 1994, the overall death rate fell from 25.1 to 4.7 deaths per 1 000 live inhabitants. There has been a corresponding increase in life expectancy: between 1940 and 1994, life expectancy for men increased from 40.4 to 69.4 years, and life expectancy for women from 42.5 to 75.8 years (Frenk et al. 1994).

In the last three decades, there has also been a change in the distribution of deaths by age group. From 1930 until the beginning of the 1970s, the prevailing pattern showed that 50% of deaths occurred in the under-5 age group and 25%

among those 50 and older. Since then, the proportion of deaths during the early years of life has begun to fall. By 1992, only one death in six (14.4%) occurred in the under-5 population, whereas one out of two deaths in men (50%) and two out of three in women (61.3%) were among those over 50 year old (Frenk et al. 1994).

Another important aspect of mortality in Mexico is related to changes in the cause of death. There has been a considerable fall in death rates from infectious diseases, diseases preventable by vaccination, and from nutritional deficiency. On the other hand, there has been an increase in the number of deaths from cancer, ischemic heart disease, and accidents. Thus, in 1940, intestinal infections and pneumonia plus influenza were the two main causes of death, accounting for 491.2 and 381.4 deaths per 100 000 inhabitants, respectively. Although these were still the primary causes of death in 1970, their rates had dropped to 149.4 and 173.5 deaths per 100 000 inhabitants. By 1994, these causes had fallen to tenth and eighth place, accounting for 11.2 and 21.0 deaths per 100 000 inhabitants, respectively.

Table 2. Principal causes of mortality, Mexico, 1970, 1980, and 1990.

	1970	1980	1990
1st cause of death	Respiratory disease	Accidents	Accidents
2nd cause of death	Intestinal infection	Heart disease	Heart disease
3rd cause of death	Heart disease	Respiratory disease	Respiratory disease

Source: Presidencia de la República Mexicana (1993).

Heart disease and malignant tumours were in 12th and 18th places in 1940, with rates of 54.3 and 23.1 per 100 000, respectively. Diabetes mellitus, with a rate of 4.2 per 100 000 did not even feature among the first 20 causes of death. At that time, heart disease, malignant tumours and diabetes accounted for only 3.5% of recorded deaths in the country. In 1970, they were in third, fifth, and 15th places, with rates of 69.4, 38.1, and 15.5 per 100 000, respectively . Together, they made up 12.2% of the total number of deaths. By 1994, they were in first, second, and fourth places, with rates of 67.5, 51.5, and 33.7 per 100 000, and their joint relative weight was 32.8%, or nine times greater than that observed in 1940. Accidents and homicide moved from sixth and 13th places among causes of death in 1940 to third and ninth places, respectively, in 1994 (Secretaría de Salubridad y Asistencia 1996).

Mortality rates, like fertility rates, vary notably by region and income level. An analysis of mortality rates by region, for example, shows infant mortality rates for 1991 that varied between 22.4 and 43.3 per 1 000, with a national average of 31.9 per 1 000. Adult mortality rates varied from 2.9 to 3.9 per 1 000, whereas the national average was 3.3 per 1 000 (Frenk et al. 1994).

The distribution of deaths by age group and specific cause also varies according to socioeconomic level, which clearly shows that there are real conditions of inequality in the country in terms of the probability and cause of death.

In the area of poverty-related illness, there has been a considerable deterioration in the nutrition status of the population. This can be seen from the increase in preschool deaths due to nutritional deficiency, which have been rising since 1983, particularly in depressed rural areas (López and Blanco 1993). The national nutrition survey reports that about 23% of children under 5 years of age are below the normal height for age. In this case in particular, economic conditions play a fundamental role. The proportion of undernourished children in areas of extreme poverty in the south of the country is four times greater than in the poorer districts of Mexico City or in the northern states (Frenk et al. 1994).

To summarize, Mexico has undergone notable demographic and epidemiological transformation over the last three decades. On the one hand, there has been a change in the population pyramid. The width of the base has tended to diminish as the proportion of children under 5 years of age decreases. The middle of the pyramid has widened with the corresponding increase in the population over 15 years of age, particularly among those over 60. And, the upper point has remained very sharp. On the other hand, epidemiological tendencies show a drop in mortality rates, with notable changes in the distribution of deaths by age group and specific cause. The considerable differences between regional, social, and economic levels, however, indicate that the prevailing epidemiological pattern in Mexico is polarized as a consequence of social inequality.

With respect to another indicator of social welfare, education, significant gains have been achieved. In 1980, 17% of the population of Mexico was illiterate but this rate had been reduced to 12.6% by 1990. As with most of the socioeconomic indicators, there are notable regional differences. In the Federal District of Mexico City and in some of the northern states, the illiteracy rate is about 4%. Official figures give the average number of years of schooling for the population older than 15 as seven. However, there is a significant educational backlog in the country, because the official figures admit that about 2 million children have never been to school (Aboites 1997).

Expenditure

If expenditure on health care is analyzed by source of financing, an initial division can be made between public and private resources. Expenditures destined for financing public institutions fall into the first group, and household expenditure on health goods and services account for the second.

According to the Fundación Mexicana para la Salud (FUNSALUD, Mexican foundation for health), 29% of the total expenditure on health between 1992 and 1996 came from employers, 22% from the government, and the remaining 49% from households, with external resources amounting to less than 1% (Hernández et al. 1997). These resources were distributed among financing funds as follows: social security funds, 43%; funds for the uninsured, 13%; funds for private medical insurance, 2%; and private funds, 42%. These funds were chaneled into the institutions that provide health care services.

Given the importance of the public sector in addressing the need for medical attention in the country, and because more information is available on

Table 3. Public expenditure on health, Mexico, 1970–90.

	Net health care expenditure (in millions)		Per-capita expenditure	
Year	**Mexican pesos (historical value)**	**US dollars**	**Mexican pesos (historical value)**	**US dollars**
1970	8 342	667	173	13.84
1971	9 488	759	186	14.85
1972	11 810	945	219	17.49
1973	13 960	1 117	245	19.63
1974	18 617	1 489	319	25.54
1975	23 922	1 914	398	31.81
1976	32 106	1 607	518	25.93
1977	44 473	1 956	697	30.65
1978	54 954	2 420	837	36.85
1979	69 247	3 037	1 026	44.98
1980	90 735	3 899	1 303	55.98
1981	135 486	5 179	1 908	72.94
1982	217 757	1 459	3 013	20.19
1983	339 960	2 107	4 626	28.67
1984	544 821	2 595	7 296	34.75
1985	688 196	1 985	11 713	26.17
1986	1 464 036	1 601	19 024	20.80
1987	3 409 690	1 532	43 678	19.63
1988	7 814 842	3 494	98 748	44.15
1989	9 307 579	3 524	116 102	43.96
1990	12 721 636	4 319	156 574	53.16

Source: Valdéz (1991).

this sector than on others, some relevant aspects of financing within the integrated public model are given in detail. The indicators for this analysis include net expenditure on health care, per-capita expenditure on health care, and the health sector's share of the gross national product (GNP), public expenditure as a whole, and social development expenditure. The distribution of resources is also briefly analyzed.

For the historical evolution of public sector financing, it is useful to use a characterization by Valdés (1991) that shows, in general terms, health care financing moving from expansion (1970–81), through crisis (1982–90), to signs of recovery at the beginning of the 1990s.

The proportion of GNP used for health care expenditure showed a constant upward tendency during the 1970s but decreased from 1983 (Table 4). The recovery of this indicator since 1992 has been consistent, with the share of the GNP used for health care maintaining an average of 4.5%.

Figures for annual per-capita expenditure on health present a similar picture: the level reached in 1990 (US $53.16) is not very different from that of 1980, but less than that of 1981, when per-capita expenditure peaked at US $72.94. In 1970, annual per capita expenditure was US $13.84, in 1981 it

Table 4. Social and health care expenditure in relation to gross national product (GNP), Mexico, 1970–90.

Year	Public expenditure as % of GNP*	Social expenditure as % of GNP*	Health** as % of GNP		
			GNP	Public expenditure	Social expenditure
1970	16.44	4.86	1.89	11.52	38.98
1971	16.82	5.33	1.94	11.51	36.35
1972	18.72	6.30	2.09	11.17	33.17
1973	20.99	6.33	2.02	9.63	31.95
1974	21.74	6.66	2.07	9.52	31.08
1975	26.37	7.33	2.17	8.25	29.68
1976	24.49	8.05	2.34	9.56	29.08
1977	23.26	7.84	2.4	10.34	30.67
1978	24.19	7.91	2.35	9.72	29.72
1979	25.02	8.43	2.26	9.02	26.77
1980	25.95	8.06	2.03	7.82	25.20
1981	29.43	9.19	2.21	7.51	24.07
1982	26.98	9.13	2.22	8.24	24.35
1983	23.75	6.66	1.9	8.01	28.57
1984	24.23	6.70	1.85	7.63	27.60
1985	22.31	6.94	1.87	8.4	26.99
1986	21.72	6.66	1.85	8.51	27.77
1987	20.29	6.21	1.76	8.69	28.42
1988	19.01	6.08	2	10.53	32.94
1989	17.39	6.17	1.83	10.54	29.71
1990	17.06	6.47	1.85	10.86	28.64

Sources: *Presidencia de la República Mexicana (1993). **Valdéz (1991).

was US $72.94, and between 1982 and 1987 it was less than US $40.00, even dropping as low as US $20.00. But it has now recovered, reaching a per-capita expenditure of US $54.30 in 1991 (Valdéz 1991).

The data on public sector expenditure, social development expenditure, and health care expenditure clearly indicate the pattern of expansion in the 1970s, crisis in the 1980s, and an apparent tendency toward recovery in the 1990s.

Moreover, there were considerable inequalities in allocating expenditure, in the form of great disparities between institutions. For example, 35.1% of public health care expenditure between 1992 and 1994 went to the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), while only 4.5% went to the Secretaría de Salubridad y Asistencia (SSA, department of health) (Hernández et al. 1997). The funds available for social security and those available for services to the rest of the population are clearly disproportionate. On average, between 1970 and 1990, of every 1 000 pesos invested in health, 742 pesos went to social security institutions and only 258 pesos to health care services open to the entire population (Valdéz 1988) — this gives the social security institutions an average advantage of 2.8:1 (Table 5). According to official figures for 1995, this difference has decreased, although it was still high, at 1.59:1 (Secretaría de Salubridad y Asistencia 1995).

During the period 1970-1995, the population covered by public health care institutions increased significantly, making these values all the more indicative of inequality in terms of access to and quality of health care. This situation is even more serious when one considers that the general living conditions of the population without access to social security are relatively unfavorable to begin with.

It is interesting to note that most of the IMSS contributions come from workers and employers, 85.2% of them on average, between 1970 and 1990. On the other hand, the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants), received 54.4% of its funding from public bodies and 37.2% from workers during the same period (Valdéz 1991).

To summarize, public health care financing has gone from a period of expansion, through one of crisis, to a period that, although it shows some signs of recovery, has still not reached levels comparable to the earlier period. As a result, it is hardly surprising that institutions making up the public health care system have faced and are facing numerous difficulties in terms of the growth, capacity, and quality of the services that they provide.

Table 5. Distribution of public expenditure on health, Mexico, 1970–90 (pesos spent out of every thousand)

Year	Social security	Population in general	Ratio
1970	802	198	4.06
1971	811	189	4.28
1972	769	231	3.34
1973	758	242	3.13
1974	768	232	3.31
1975	760	240	3.17
1976	788	212	3.71
1977	749	251	2.98
1978	726	274	2.65
1979	707	293	2.42
1980	706	294	2.40
1981	706	294	2.40
1982	731	269	2.72
1983	745	255	2.92
1984	735	265	2.77
1985	724	276	2.63
1986	696	304	2.29
1987	712	288	2.47
1988	744	256	2.90
1989	738	262	2.82
1990	716	284	2.52

Source: Valdéz (1991).

As mentioned earlier, there is insufficient information on the private sector. Some indicators exist, however, that reflect its financial importance in the system as a whole. Between 1982 and 1987, the private sector accounted for 44.16% of total health care as a percentage of GNP (Ruiz et al. 1988).

Coverage

Many difficulties arise in analyzing official data on health care coverage. A major difficulty is the lack of uniformity in the concepts used. According to the department of health (Secretaría de Salubridad y Asistencia 1995), information on coverage may be obtained in the form of nominal coverage (the number of people entitled to receive services), but only for social security institutions; potential coverage (the number of people who can be cared for with the resources available); and real coverage (the number of people who actually used the services in a given year). Other difficulties include the diversity of methods used for generating information, inconsistency in this information, and a lack of data on some of the sectors that provide services. Because of these problems, the values presented must be considered as approximations only.

Estimates of the total capacity for coverage show that, for 1978, social security institutions could cover 24.0% of the total population, institutions open to the population in general 18.4%, and private services 12.3%, leaving 45.3% of the population (about 29.63 million inhabitants) with no coverage (COPLAMAR 1985).

In an effort to extend coverage, numerous government initiatives were introduced between 1979 and 1982 to open more services to underprivileged sections of the rural and suburban population. The most widespread and complete of these was the program known as IMSS-COPLAMAR. IMSS stands for Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), while COPLAMAR stands for Coordinación General del Plan Nacional de Zonas Deprimadas y Grupos Marginados, (COPLAMAR, national program for depressed areas and marginal groups). Since 1982, IMSS-COPLAMAR has been known as IMSS-Solidaridad (IMSS solidarity).

As a result of these programs, the proportion of the population with access to medical services has greatly increased. Some studies indicate coverage rates of between 75.0% and 82.2% of the population, reaching nearly 89% by 1990. This would mean that about 11% of the inhabitants of the country or 9.5 million people still had no access to any kind of medical services at that time (Frenk et al. 1994). However, official data on real coverage, meaning actual use of health services, was 55.8% of the population in 1990 and 70.1% in 1995 (Table 5).

It should be pointed out that data on the distribution of coverage does not make a distinction between services provided by the public sector and services provided by the private sector. It is assumed, however, that private medical insurance coverage is still minimal, estimated at 2% by some sources (Frenk et al. 1994).

Thus, the issue of coverage remains one of the most critical problems facing the system. During the process of reform, various strategies for extending coverage were proposed in the national health programs for 1984–88 (Poder Ejecutivo Federal 1984) and 1989–94, as well as in the social security reform bill and the Programa de Reforma del Sector Salud 1995-2000 (PRSS, health care sector reform program 1995-2000) (Secretaría de Salubridad y Asistencia 1996).

Subsystems

There are two basic dimensions to the structure of the Mexican health care system (Frenk et al. 1994): social groups and system functions. A fundamental distinction can be made between two social groups: those who are insured and those who are not insured. The vast majority of the insured are covered by social security, as the private sector covers only a very small section of the population. Those who are not insured fall into two groups: the poor, both urban and rural, who are excluded from social security because they do not participate in the formal sector of the economy, and the self-employed or professional middle class, especially urban middle class, who are not protected by social security and have not acquired private medical insurance.

The main problem that arises in relation to the functions of the system comes from the fact that the various social groups are segregated into different subsystems. The present system can be characterized as "vertically integrated" but "horizontally segregated." That is, each institutional group (social security, general population, or private sector) carries out its functions independently.

This system structure gives rise to many problems, especially the duplication and waste of resources and the establishment of monopolies for the respective clients. Perhaps the most serious problem, however, is the overlap in demand, because a large number of those with social security also use the private sector and the institutions run by the Secretaría de Salubridad y Asistencia (SSA, department of health). In these cases, the insured patient pays twice or even three times, resulting in what is known as multiple contribution.

The institutions in the social security group are the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security); the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants); the Instituto de Seguridad para las Fuerzas Armadas Mexicanas (ISFAM, social security institute for the Mexican armed forces), and medical services provided by and for the national oil company (PEMEX), the Secretaría de la Defensa Nacional (SDN, department of national defense), the Secretaría de Marina (SECMAR, navy department), and the Sistema de Transporte Colectivo del Metro (underground transport system).

Services for the general public are provided for by the SSA, the Sistema Nacional para el Desarrollo Integral de la Familia (DIF, national system for the integrated development of the family), the medical services of the Departamento del Distrito Federal (DDF, the administration of the Federal District of Mexico City), and IMSS-Solidaridad (IMSS solidarity).

Organization and provision of health services

As mentioned earlier, the system separates the population into insured and uninsured. Within the first group, there is a wide range of options that are related to the way people are tied to the formal sector of the economy; in the second group, there is a distinction between the poor and those of the middle class, who for various reasons are covered by neither social security nor private insurance. This diversity is reflected in the large number of institutions that not only provide health care services, but also finance and administer those services. This organization of the system results in a duplication of supply, waste of resources, unfair costs to users, and serious problems of coordination (Frenk et al. 1994).

Three different types of institution provide social security to the population: the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), which basically covers industrial workers; the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants), which covers civil servants; and institutions that offer health care for specific employers. The uninsured population receives health care in institutions that are considered to be for the population in general, such as those of the Secretaría de Salubridad y Asistencia (SSA, department of health), Sistema Nacional para el Desarrollo Integral de la Familia (DIF, national system for the integrated development of the family), and IMSS-Solidaridad (IMSS solidarity). A tiny segment of the population (2%) uses prepaid services and an unknown number pay directly for the use of private services.

Since 1984, there have been attempts to bring some order to the sector, using the SSA in a regulatory role, but these attempts have been unsuccessful. The Programa de Reforma del Sector Salud 1995-2000 (PRSS, health care sector reform program 1995-2000) has taken up these proposals (Secretaría de Educación 1996), indicating the urgency of the need for organization. The reform program proposal also encourages social security institutions to separate the financing function from the provision of services function. There is also, for the first time, official recognition of the private sector and of the need for its extension through an increase in new kinds of insurance.

Resources for the provision of services

The personnel and material resources available to the institutions, and the development of provision of health care services (Tables 6–10) are discussed in this section.

Public sector

Over the past 25 years, there has been a notable increase, in absolute terms, of material and human resources in the health care system as a whole. A considerable difficulty for analysis arises from the complete lack of information on the private sector prior to 1991. Nevertheless, the data on the increase in resources in the public sector give an idea of the magnitude of the increase within the system as a whole. In the public sector between 1970 and 1995, the number of medical units grew by 279%, with more emphasis on ambulatory facilities than hospitals; the number of beds increased 102%; and the number of physicians increased more than 400%. From 1980 to 1995, the number of consulting rooms increased 121%.

It is worth noting that the rate of growth in the public sector has not been constant over this period. The greatest increases occurred between 1970 and 1980: 94% for medical units; 57% for numbers of beds; 75% for number of consulting rooms; and slightly over 200% for total number of doctors. From 1980 to 1990, the increases were notably less for medical units (65%) and human resources (31%) and dramatically so for number of beds (only 5.8% in this

Table 6. Medical health centres, Sistema Nacional de Salud, Mexico, 1970–95.

Year	Private sector: Voluntary with out-of-pocket payment or voluntary contract	Public sector: Integrated public	
		Social security*	General population**
1970	N.D.	2 030	2 066
1975	N.D.	2 493	2 454
1980	N.D.	2 667	5 316
1985	N.D.	3 030	7 705
1990	N.D.	3 343	9 848
1991***	1 790	3 411	10 401
1992	2 705	3 453	10 719
1995	2 816	3 606	11 919
		Percentage increment in the public sector	
		1970–95	279
		1970–80	94
		1980–90	65
		1990–95	17

Sources: 1970–1975: Valdéz (1991). 1980–1995: Secretaría de Salubridad y Asistencia (1994c, 1995).

* Includes: *IMSS*, *ISSSTE*, *PEMEX*, *SDN*, *SECMAR*, and state-level *ISSSTE*.

** Includes: *SSA*, *DDF*, and *IMSS-COPLAMAR* (*IMSS-Solidaridad* since 1990).

*** State-level units are included as from this year.

period). Over the same period, the number of consulting rooms increased 75%, the same growth rate as between 1970 to 1980. Records for the first part of the 1990s appear to confirm a slowing in the growth in numbers of medical units and consulting rooms (17% and 25%, respectively, by 1995), whereas the increase in human resources and the number of beds has risen again (37% and 21%, respectively).

Within the public sector, the institutions open to the population in general have experienced greater growth than social security institutions in all areas except for the number of beds, where the increase has been similar.

Data for the last 5 years (1991–95) indicate a contraction of the public sector relative to the private sector, both in terms of facilities and human resources. In the private sector, there has been an increase of 57.0% in the number of medical units,

Table 7. Consulting rooms and beds, Sistema Nacional de Salud, Mexico, 1970–95.

	Private sector: Voluntary with out-of-pocket payment or voluntary contract		**Public sector: Integrated public**			
			Social security*		**General population****	
Year	**Consulting rooms**	**Beds**	**Consulting rooms**	**Beds**	**Consulting rooms**	**Beds**
1970				21 257		16 519
1975				29 497		14 641
1980			11 693	36 110	8 042	23 522
1985			13 631	36 968	13 795	22 282
1990			17 157	38 050	17 567	25 072
1991***	7 500	21 895	17 606	38 189	18 704	29 514
1992	8 349	31 062	18 536	39 181	19 485	32 319
1995	12 022	34 496	20 792	41 128	22 878	35 514
	Percentage increment in the public sector					
1970–95		102				
1970–80		57.8				
1980–90	75	5.8				
1990–95	25	21.4				

Sources: 1970–75: Valdéz (1991). 1980–95: Secretaría de Salubridad y Asistencia (1994c, 1995).

Note: The data on private sector consulting rooms include both general practices and specialization.

* Includes: IMSS, ISSSTE, PEMEX, SDN, SECMAR, and state level ISSSTE. The figure for 1980 includes information corresponding to Ferrocarriles Nacionales

** Includes: SSA, DDF, IMSS-COPLAMAR (IMSS-Solidaridad since 1990). The figure for 1980 includes information corresponding to DIF.

*** State level units are included as from this year.

57.5% in the number of beds, 60.2% in the number of consulting rooms, and 440% in number of doctors, compared to 12.0%, 13.2%, 20.2%, and 23.5%, respectively, in the public sector. The information regarding doctors needs further analysis, however, because it is estimated that only 30% of doctors work full time in private practice, while the remaining 70% work in both sectors.

Public and private sector

The majority of physical and human resources are concentrated in the public sector. The share of the private sector has increased over the last few years, however. By 1995, 15.5% of medical units, 31.0% of beds, 21.6% of consulting rooms, and 36.6% of doctors were in the private sector.

An analysis of the distribution of resources in the public sector shows that the institutions that are open to the population in general have more medical

Table 8. Office visits by patients, Sistema Nacional de Salud, Mexico, 1970–95.

	Private sector:	Public sector: Public integrated	
Year	Voluntary with out-of-pocket payment or voluntary contract	Social security*	General population**
1970		11 963	6 746
1975		17 450	10 076
1980		33 881	22 540
1985		37 642	23 542
1990		44 935	29 121
1991***	10 868	49 603	32 708
1992	33 626	49 875	36 612
1995	58 724	55 380	46 295
		Percentage increment in the public sector	
		1970–95	443.45
		1970–80	201.57
		1980–90	31.25
		1990–95	37.29

Sources: 1970–75: Valdéz (1991). 1980–95: Secretaría de Salubridad y Asistencia (1994c, 1995).

Note: The figures for private sector doctors do not separate doctors in contact with patients from those with other duties. They also include full- and part-time doctors and those who have legal contracts with health centres for the use of installations or sporadic attention to individual patients according to their specialties but who do not form part of the staff. These doctors represent almost 50% of those reported.

* Includes: IMSS, ISSSTE, PEMEX, SDN, SECMAR, and state level ISSSTE. The figure for 1980 includes information corresponding to Ferrocarriles Nacionales

** Includes: SSA, DDF, IMSS-COPLAMAR (IMSS-Solidaridad since 1990). The figure for 1980 includes information corresponding to the DIF.

*** State level units are included since this year.

Table 9. General office visits versus hospital admissions, Sistema Nacional de Salud, Mexico, 1970–95 (values in thousands).

	Private sector: Voluntary with out-of-pocket payment or voluntary contract		Public sector: Public integrated			
			Social security*		General population**	
Year	General consultations	Hospital admissions	General consultations	Hospital admissions	General consultations	Hospital admissions
1970			44 298	907	9 147	306
1975			56 023	1 372	12 345	348
1980			47 943	1 815	19 518	485
1985			63 108	2 301	25 404	696
1990			67 773	2 234	32 574	1 035
1991***			66 641	2 297	34 296	1 073
1992			68 327	2 320	34 535	1 147
1995	3 192	887	82 508	2 491	42 929	1 665

Sources: 1970–80: Valdéz (1991). 1985–95: Secretaría de Salubridad y Asistencia (1994c, 1995).

* Includes: IMSS, ISSSTE, PEMEX, SDN, SECSMAR, and state level ISSSTE. The value for 1980 does not include information corresponding to the SDN.

** Includes: SSA, DDF, IMSS-COPLAMAR (IMSS-Solidaridad since 1990). The value for 1980 includes information corresponding to the DIF.

*** State level centres are included as from this year.

units (3.3:1) and more consulting rooms (1.1:1) than the social security institutions, whereas the social security institutions have more beds (1.15:1) and doctors (1.19:1).

If, however, these resources are analyzed relative to population served, the institutions open to the general population clearly have fewer resources. For either potential or legal populations, for every 100 000 inhabitants, institutions open to the general population had 111.0 doctors, 183.6 nurses, 47.7 consulting rooms, and 83.7 beds; whereas social security institutions had 121.1 doctors, 218.4 nurses, 45.5 consulting rooms, and 89.9 beds. During 1990, the social security institutions had almost double the resources of public institutions (Secretaría de Salubridad y Asistencia 1995), indicating a serious disproportion in the distribution of resources.

It is clear that although the government has attempted to strengthen public health care institutions, it has not yet succeeded in providing the services required by the population in terms of quantity and, especially, quality.

Similarly, strengthening the institutions for the general population has not rectified the basic inequity in the distribution of resources throughout the country. For example, in 1992, only 13 of the 32 states reached the national average for the number of beds, only eight states reached the national average for the number of consulting rooms, and only 13 attained the international standard

Table 10. External office visits at health centres versus hospitalization health centres, Sistema Nacional de Salud, Mexico, 1980–95.

	Public integrated sector			
	Social security*		General population**	
Year	External consultation	Hospitalization	External consultation	Hospitalization
1980	2 371	296	5 140	176
1985	2 705	325	7 467	238
1990	2 925	421	9 554	294
1991***	2 988	423	10 052	349
1992	3 030	423	10 309	410
1995	3 081	437	11 046	360

Source: Secretaría de Salubridad y Asistencia (1994c, 1995).

Note: The external consultation centres cover first level care, hospital centres include secondary and tertiary level care.

* Includes: IMSS, ISSSTE, PEMEX, SDN, SECMAR, and state-level, ISSSTE.
** Includes: SSA, DDF, and IMSS-COPLAMAR (IMSS-Solidaridad since 1990).
*** State-level health centres are included as from this year.

for the number of doctors per inhabitant. In fact, this last standard is only satisfied by eight states with respect to institutions open to the general population and by 17 states for social security institutions. In the case of the Secretaría de Salubridad y Asistencia (SSA, department of health), responsible for health care services in the poorest states, the data show that the areas of most need are those with the fewest resources, especially doctors. For example, in Chiapas there are only 51.7 doctors per 100 000 inhabitants, compared to the national median of 95.2 per 100 000. Of these, about 50% of the doctors who care for the general population are interns or have not yet obtained their full professional qualifications (Secretaría de Salubridad y Asistencia 1994b).

Between 1980 and 1995, there was an 86% increase in the number of general consultations in the public sector, and an 80% increase in the number of hospital admissions, with the greater part of the increase occurring in institutions for the general population. There were, however, still notable differences in 1995 in the number of services provided. Social security institutions provided 65.7% of general consultations and 59.9% of hospital admissions, which can be explained by the lower number of doctors, beds, and economic resources available in the public health services for the general population.

When the public sector is compared to the private sector, official information shows that 97.51% of general consultations occur in the public sector, as well as 82.4% of hospital admissions. But, these values obviously underestimate the private sector's real share. In fact, the government itself recognizes that the private sector provides about 32% of medical consultations, and that this proportion is higher for the lowest income groups, where about 41% of contacts with doctors are in the private sector (Secretaría de Salubridad y Asistencia 1996).

To summarize, there has been an increase in health resources in absolute terms. In the public sector, this growth has focused on strengthening public institutions, especially in the areas of primary care and ambulatory services, and primary health personnel. Nevertheless, these measures do not appear to have solved the many problems that exist in the public sector. As a result, there is room for growth in the private sector, especially in the area of hospital services.

Changes in the Health Service System

This section will analyze the changes that have occurred in the subsystems within the Mexican health care system over the last 25 years by describing the health care subsystems prevalent from 1970 to 1995 and the changes that they have undergone. Two different periods are considered: first, the 1980s, when organizational and administrative changes were made that led to the formation of the Secretaría de Salubridad y Asistencia (SSA, department of health); and, second, the most recent period since the reform of the social security system. Tendencies will be identified, the most important of which is the emergence of the public contract subsystem.

Two initial observations must be made. First, the aspects considered relevant in characterizing the subsystem are financing, provision, methods of payment, relations between the different participants in the system, and regulation. This approach fundamentally considers the first two aspects — financing and provision. Second, because of the historical process in which it has developed, the health care system in Mexico has been characterized by the coexistence of a wide variety of means of access, types of organizations, provision, and even financing, so that any attempt at grouping is very complicated. For this reason, the analysis considers the most representative options.

When analyzing the Sistema Nacional de Salud (SNS, national health system), with particular reference to financing and provision during the period from 1970 to 1995, the various options for health care can be grouped into four models: the integrated social security subsystem, the integrated public subsystem, the voluntary contract subsystem, and the public contract subsystem.

The integrated social security subsystem is characterized by compulsory financing through income-related contributions. Provision is by public institution. Payment of providers by users is indirect through public financing bodies that provide wages and, in the case of institutions, prospective budgets.

The integrated public subsystem for the population in general is funded by the state through general taxation. Payment to institutions and workers is based on prospective budgets and salaries, respectively. These institutions also charge for services based on the economic capacity of the user. However, these charges have had a minimal economic impact.

The voluntary contract subsystem is made up of so-called prepaid private services. Financing in this subsystem is voluntary and services are provided by independent professionals and institutions. The method of payment is indirect, through insurance companies on a fee-for-service or per-capita basis.

The public contract subsystem is the model that is considered to have emerged as a result of changes in the social security system since 1995. Under this model, financing is based on compulsory income-related contributions, services are provided by public or private institutions, and medical services are contracted from the private sector on a return-of-contributions basis. Although regulations have not yet been established to standardize payment to companies, it is already known that employers will be able to retain up to 40% of health insurance contributions, which they will then be able to use to contract for the kind of service they choose.

Organization of the health service system

Traditionally, the health care system in Mexico has been based on a clear differentiation between two sectors, public and private. Within the public sector, both subsystems correspond to the integrated public model, because there is no separation between financing and provision. Nevertheless, there are differences in financing and in the population covered that make them independent of each other.

In the integrated social security subsystem, social security institutions are financed by compulsory income-related contributions. At present, these institutions cover about 51% of the population. Public institutions provide the health care services and doctors are salaried.

The institutions grouped in the integrated public subsystem for the population in general are financed out of general taxation, through funds that are specifically allocated at the central level, both for national and state institutions. Theoretically, these institutions cover 49% of the population but, because there is no compulsory affiliation, it is estimated that about 11% of the population is without any kind of medical coverage at all. The definition of priorities and the distribution of resources all takes place at the central level, and depends very much on the prevailing political environment.

The voluntary contract subsystem, which has only been identified as recently as the second half of the 1980s, is made up of a great number of private hospitals that offer service by contract. These hospitals are complementary to the social security subsystem, since they generally handle only emergency situations. Although these services cover only 2% of the population, the speed with which they have increased over the last decade indicates that this is an option that will play an important role in the future. Financing is by prepayment and doctors are paid on a fee-for-service or per-capita basis.

The public contract subsystem is in a period of gestation, but it will be the first institutionalized experience of the public-private mix.

Relationship between payers and providers

For the integrated public social security subsystem, the allocation of resources to providers has been very centralized, even in states that were decentralized in the 1980s. The only decentralized Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) program was IMSS-Solidaridad (IMSS solidarity). Allocation was provided through a yearly budget. The Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants) and other smaller institutions that provide social security have bipartite financing (workers and the federal government). The IMSS has tripartite financing, from workers, employers, and the federal government. The percentage paid by each party varies from institution to institution. Doctors are paid fixed salaries that are defined on a sliding scale (Barreiro 1997).

Doctors are organized into unions. The union of IMSS workers provides some of the best benefits for its members. This body has been very active in opposing the changes proposed by the reform since the mid-1980s. The ISSSTE workers also have an organized union but it is corporate in nature, and represents its members through direct negotiations with the state. In general, all institutions in this part of the sector are regulated in a similar way, but each institution defines the specific points as to amounts, forms of payment and benefits for its workers according to criteria resulting from its individual history and dynamics.

The amount of work has been determined to date by demand and there have been no incentives to economize. As in most other state-supported institutions, incentives for punctuality and productivity have been introduced in recent years. There has been little control over the prescribing of pharmaceuticals in the past, but this is now very strictly controlled. The purchase of pharmaceuticals is regulated by the state on the basis of what is known as "consolidated purchase bidding," with each institution having an official list of approved medicines for use in public health institutions, that of the IMSS being the most complete.

Before decentralization in 1986, the allocation of resources in the public subsystem was very centralized, like that of the social security model. Since then, 14 of the 32 states have been decentralized. Decentralization has resulted in better services in the more affluent states, but deterioration of services in the poorer ones, accentuating the differences between them. Between 1983 and 1987, state governments received only about 9.7% of all the resources allocated to the integrated public subsystem (Ruíz et al. 1988). There have been several decentralizing initiatives since 1990, but these have not been very efficient. Examples are the Sistemas Locales de Salud (local health care systems) and the Programa de Apoyo a los Servicios de Salud para la Población no Asegurada (PASSPA, support program for health care services for the uninsured). This latter program was applied in the four poorest states of the country and its effect tended toward centralization rather than decentralization (González-Block et al. 1997).

Hospitals receive payment through annual budgets. Fixed salaries are paid, which are independent of productivity. The workers in this part of the sector are also union members, but their working and economic conditions are not as good as for those working in the social security sector. There are few incentives for improving the efficiency or productivity in these institutions.

Although ambulatory services do not provide drugs, the Secretaría de Salubridad y Asistencia (SSA, department of health) has an official list of approved medicines through which prescriptions are regulated both outside hospitals and, especially, within them. This list is based on the programs of the institution and makes a priority of using mono-pharmaceuticals, that is, medications with a single active ingredient. The volume of work is determined by demand and there are no incentives for efficiency or economy, although it must be said that the present conditions of austerity and deterioration make such incentives unnecessary.

The voluntary contract subsystem is composed of prepaid services that provide health care on a profit-making basis. Financing is voluntary. Unfortunately, there is a lack of data as to the resources handled by the subsystem, although there is no doubt as to its importance within the health care system. Services are provided by private professionals and institutions. Providers receive payment from insurance companies on a fee-for-service or per-capita basis.

Relationship between patients and providers

Within the integrated public social security subsystem, service providers, professionals, and institutions belong exclusively to the public sector, although important changes are sure to result from the modifications to the social security act. Social security institutions, particularly the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), absorb a high proportion of the resources in this sector. The last 15 years of financial austerity, however, have caused a considerable deterioration in the services that these institutions provide.

These institutions offer ambulatory and hospital services, including primary-, secondary-, and tertiary-level care. The general health law stipulates that these institutions should participate in national health campaigns, and they play an important role in this area.

The family doctor is the gatekeeper to the subsystem, with the power of referral to secondary or tertiary levels as necessary. Patients cannot choose their doctor, who is assigned by the institution.

There is no out-of-pocket payment. Nevertheless, the lack of medical supplies means that patients often have to buy their own. The social security institutions, especially the IMSS, are still in the forefront of medical and hospital technology, although specialized services are being used to full capacity, so access to complex technology is not easy.

The services of the integrated public subsystem for the population in general are geographically separate, and access is defined by this characteristic. They provide ambulatory and hospital care. The Secretaría de Salubridad y Asistencia (SSA, department of health) is responsible for health policy and is, therefore, responsible for creating programs for the sector as a whole. In this capacity, it is the primary promoter and provider of preventive health care, such as vaccination, diagnosis and detection of disease, and care of healthy children. The services do not include the provision of drugs through walk-in consultations.

Initial contact with the system is through a general practitioner, who may refer the patient to secondary or tertiary level. There are no mechanisms in these institutions either, for the patient to choose his or her doctor. An out-of-pocket co-payment is usually charged for walk-in consultations. Although this is generally quite small, it has been increasing since the mid-1980s. This co-payment is not regulated in any way, and each institution fixes the charges and the way in which they are set. The amount of co-payment for hospitalization is based on a socioeconomic evaluation of each user.

Most public hospital services for the population in general (public decentralized SSA organizations, some national institutes, the Sistema Nacional para el Desarrollo Integral de la Familia (DIF, national system for the integrated development of the family), the Departamento del Distrito Federal (DDF, administration of the Federal District of Mexico City), and some states and municipalities have co-payment charges. The amount paid and payment conditions vary from institution to institution (COPLAMAR 1985).

As a whole, the integrated public system has been characterized by the impossibility for the user to choose a particular provider. This, together with various deficiencies in the quality of services provided, has justified a tendency to lay blame for the deterioration in services on the professionals and to call for the introduction of user choice of provider. This evaluation does not take into consideration, however, the role that serious under-financing has played in the deterioration of public institutions. Given the prevailing economic conditions, it is doubtful that the selection of doctor would result from free choice or need, but rather would depend on the purchasing power of the individual. Access would be differentiated on the basis of wealth.

Although there is insufficient information, some studies have found that the voluntary contract subsystem is used mainly to provide obstetrics and gynecology, surgery, and psychiatric services. The market available to the private sector is not large enough to permit the use of advanced technology or subspecialties that are becoming increasingly refined and expensive. This subsystem has, therefore, tended to provide less-expensive services (COPLAMAR 1985). Nevertheless, in recent years, the sector has grown into a sizeable industrial-medical complex that uses high technology and is concentrated in large urban centres. Payment is indirect, through prepaid premiums, but in most cases an initial down payment must be made for each service. This out-of-pocket expense, which is often beyond the means of the user, discourages the use of this option.

Relationship between population and payers

At present, the integrated public social security subsystem covers about 51% of the population of Mexico, both those directly insured and their dependants. Financing is tripartite with contributions from employers, the state, and workers. It should be pointed out that, in the case of the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security), workers' and employers' contributions cover most of the financing (85.2% on average between 1970 and 1990), whereas in the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, social security institute for civil servants), a greater proportion of the contributions come from public bodies (54.4% versus 37.2% from workers and employers in the same period). Access is determined by affiliation, which in turn depends on being part of the labour market, for the most part in industrial activities, although some groups of workers from state-supported organizations are also affiliated. Medical benefits are also provided to workers' families. The subsystem is geographically divided according to users' place of residence. Nearly all institutions of this type provide additional benefits such as prescription medicines, child-care centres, retirement pensions, recreational facilities, and insurance against occupational hazards.

Theoretically, all those who are not covered by social security, mainly low-income people who are not involved in the formal labour market, have access to institutions in the integrated public subsystem for the general population. There is a small sector of the middle class that uses the integrated public services, especially those high-quality specialized services available at the institutes. In this case, access is through out-of-pocket payment and the cost is based on a socioeconomic evaluation of the user, although it can be similar to the most expensive of private services.

As was mentioned earlier, only about 2% of the population are covered by the voluntary contract subsystem. More detailed analyses show some interesting facts. Because of regional income differences, the acquisition of private medical insurance is more common among the urban population and in the north of the country. In the urbanized areas of the north, 5% of the population has private health insurance and, in Mexico City, about 3% has (Knaul et al. 1977). On the other hand, recent data show that about 42% of the population use private services, both ambulatory and hospitalization. This includes those who pay for such services directly out-of-pocket.

The emerging model

Modifications to the Ley del Seguro Social (social security law) and, more generally, legislative changes with respect to health care services, are very recent The social security law came into effect only in July 1996. Thus, this section will be limited to an observation of possible tendencies resulting from the changes to the Sistema Nacional de Salud (SNS, national health system). These will no doubt be significant, but are not yet clearly defined. Therefore, the following statements are provisional, and some aspects of the relationships between the participating parties can only be sketched, because it is not yet clear how they will develop in the future.

In general terms, the characteristics of the subsystems that have already been described will continue in the future. Perhaps the most important changes, those that will define the different relationships between the parties involved in health care services, will be the emergence of the public contract subsystem and the expansion of the voluntary contract subsystem.

Public contracting has been allowed under the law governing the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) for several decades, but it has had a limited impact and played practically no role in the general orientation of the Sistema Nacional de Salud (SNS, national health system). Nevertheless, the reforms that were advanced in 1995, both for social security and within the institutions for the population in general, make feasible a considerable increase in the use of public contracting for services. This will be the first institutionalized experience of a public-private partnership in Mexico.

In general, we believe that the emergence of this subsystem and the expansion of the private contract subsystem will shape new relationships between the public and private sectors. The relationships between the different parties are presented below, with emphasis on the changes that may take effect in the future.

Relationship between payers and providers

In the integrated public subsystem, the priority among the changes proposed by the Programa de Reforma del Sector Salud 1995-2000 (PRSS, health care sector reform program 1995-2000) is decentralization. As has been seen, the first initiatives in this respect appeared at the beginning of the 1990s in programs for decentralizing public health care services to the state level. But by 1994, only 13 of the 32 states in the country had decentralized health care services. In a government report of September 1997, the President of the Republic indicated that the decentralization process was nearly 100% complete. This is evidence of the importance that the present administration places on decentralization. But given the speed with which it has been brought about, it seems reasonable to suppose that its achievements will be limited in the immediate future.

In the most recent reform initiatives, the decentralization process has concentrated on setting up state and municipal health care systems through the *Municipio Saludable* (Healthy Municipalities) program, which proposes the participation of local communities in defining priorities, and drawing up, implementing, and evaluating local health care programs. Another important change will be the decentralization of IMSS –Solidaridad (IMSS solidarity) and its transfer to state health care systems.

Of course, the decentralization process is intended to allocate federal resources to the states in a more equitable manner, and also to mobilize greater effort by state and local authorities in collecting funds destined for health care services. In general, however, other aspects of the relationship between payers and providers will remain unchanged.

In the emerging public contract subsystem, which is closely tied to the integrated public social security subsystem, financing will be compulsory, with resources coming from the existing social security systems, using the mechanism of return-of-contributions that was described earlier. Contributions will continue to be made by the state, employers, and workers. The return-of-contributions mechanism will relieve problems resulting from the inability of institutions to respond to the need for care by the insured population. From the financial point of view, however, the withdrawal of workers with higher contribution rates, about 31%, will mean the loss of valuable resources. In fact, if all high contributors move to the private sector, the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) will retain 70% of the users but only 49% of the resources (Laurell 1996).

Also, because of the financial crisis in sickness and maternity insurance — the result of the growing imbalance between the population covered (workers and dependants) and the contribution scheme — a new model for contributions has been proposed in addition to the return-of-contributions scheme. In the case of maternity insurance, workers' and employers' contributions will be reduced by about 33% and this reduction will be covered by an increase in the federal contribution. For workers who earn less than three times the minimum wage, there will be a fixed payment made only by employers and the government. For workers who earn more than this, an additional 6% will be paid, again, by the employers and the state.

There is insufficient information at present to indicate what level of economic relationship will exist between the IMSS and companies. The only mechanism that is clearly defined is that the companies choosing to take advantage of the return-of-contributions system will retain about 40% of their total contributions to use for establishing contracts for medical services covered by the sickness and maternity insurance.

The IMSS is, therefore, in a difficult situation because of the possibility of losing those groups that pay the most and being forced to depend, to a great extent, on government efficiency in tax collection for its revenues, the government being one of the highest contributors since the reform. At the same time, the IMSS will be forced to improve as a service provider in order to compete with the private sector for the provision of services to the informal sector of the population, which will be incorporated through the new family insurance program.

In the public contract subsystem, providers will be paid indirectly through company sickness funds or public financing organizations. The latter, if they are established, will pay on a fee-for-service or per-capita basis, with the parallel introduction of incentives to encourage productivity. A high proportion of social security doctors are expected to work also for those private establishments that provide services through the voluntary contract scheme, once it becomes established.

Finally, there are plans to reorganize public institutions with regard to negotiating collective agreements for workers, on the basis of the new institutional reality and of a possible cut-back in the numbers of workers.

Relationship between patients and providers

Theoretically, the integrated public subsystem for the population in general will be reorganized to increase user choice. The reform program also envisages the introduction of incentives for good service. Although the providers in this model remain the same, it should be mentioned that services will be based on "packages" that will be defined according to cost-effective parameters based on the socioeconomic conditions of the population to be served. To increase efficiency, the unit cost of each intervention will be calculated. Also, it is expected that the current prevalence of direct payment will be increased.

An evaluation has shown that users prefer private over public sector consultation when they can afford it. Constant complaints are made about waiting time and the treatment received in the institutions that make up the integrated public model, both those of the social security and those open to the population in general. This has to do with the critical financial situation in the sector. Secondary- and tertiary-level services in the public sector have a better image; those who can generally make use of them, especially since the cost of such services in the private sector is a real obstacle to access.

This is the reason why there will be a combination of public and private institutions and public and private professionals in the public contract subsystem. The kind of institution or professional used will depend, among other things, on the kind of service to be provided. Thus, users will be expected to turn to independent professionals and institutions for primary attention, while relying on public sector professionals and institutions for hospital care.

Diversification of insurance plans is also expected both in the public contract subsystem and in the voluntary contract subsystem because, at present, most of these only cover extreme situations.

Relationship between population and payers

The most important change in the relationship between the population and payers affecting the integrated public subsystem has to do with the introduction of a basic care package. Adoption of the package was encouraged during the 1980s and has become especially important under the Programa de Reforma del Sector Salud 1995-2000 (PRSS, health care sector reform program 1995-2000). Apparently, the intention is to concentrate the greatest effort on the poorest urban and rural areas, in such a way as to avoid duplication of effort in covering this population.

The basic care package is defined as "the minimum number of health care interventions that must be provided to any population with respect to priority needs (risk factors, injuries, and sickness)" (Secretaría de Salubridad y Asistencia 1996). The package will include clinical, public health, and health promotion interventions that are easy to implement at low cost and with high impact. It will cover areas such as basic family health; family planning; maternal and child health; oral rehydration therapy; antiparasite treatment; management of acute respiratory problems; prevention and control of pulmonary tuberculosis; prevention and control of high blood pressure and diabetes mellitus; accident prevention and first aid; and community training in personal health care. The package is to be applied in 380 extremely poor municipalities in 11 states, where 4 million people live, 30% of whom have no access to any regular source of medical attention.

Traditionally, the extension of coverage under the social security subsystem, particularly the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) has been based on expanding eligibility to additional sectors of the population. The latest initiative along these lines has been the creation of family health insurance, which is directed at workers in the informal sector.

More particularly, changes that have been put into effect in this subsystem indicate different reforms for different insurance plans, specifically sickness and maternity insurance, and disability, old age, retirement, and life insurance.

The central proposal for sickness and maternity insurance concerns defining a package of services to be covered by this insurance, opening up coverage to workers in the informal sector by means of the family health insurance, allowing the option of contracting with the private system, and subcontracting certain services. To this end, a single, uniform, indexed contribution will be established, which, unlike the contributions that have been made in the past, will not be proportional to salary.

Contributions and benefits for disability, old age, retirement, and life insurance will be strictly correlated, with a system of individual accounts and the opening of the insurance plan to unsalaried sectors of the population. In other words, this will be a compulsory retirement insurance plan with individual capital funds. The main purpose of this change is to make the various branches of the insurance plan viable without increasing (in fact, decreasing) worker and employer contributions, and by complementing payroll deductions with general fiscal resources and including new kinds of worker. This measure actually favours various Asociaciones de Fondos para el Retiro (AFORES, associations of retirement funds) that will be responsible for providing workers' retirement pensions in the future.

Lastly, the public contract subsystem is expected to absorb about 30% of the population covered at present by the IMSS, mainly those groups paying the highest contributions, as mentioned earlier. Since the changes to the social security law have come into effect, there have already been cases of medical services being contracted through the return-of-contributions option in the northern part of the country.

The voluntary contract model is likely to increase in the future because its target population is the workers in the informal economy who are to be incorporated into the IMSS. Fierce competition is expected between the IMSS and private insurance companies over the provision of this kind of service.

Regulation

The regulation of health care services in Mexico has been identified as one of the greatest challenges for the Sistema Nacional de Salud (SNS, national health system). The state has always predominated in health policy-making, and it would be true to say that civilian society has not participated in any way in the definition of health care policy. There is, therefore, vertical decision-making, with the state as main protagonist. The principal aspects of health care services regulation may be found, therefore, in the legal documents referring to health care that were summarized in the previous section.

Various authors believe that regulation is very weak and unresponsive to the needs and challenges arising from the changes taking place within health care institutions. One of the challenges for the future is considered to be the formation of a regulatory body with the capacity to establish standards and regulations for the whole sector (Frenk et al. 1994).

Traditionally, the Secretaría de Salubridad y Asistencia (SSA, department of health) has been assigned the role of regulator, but in practice the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security) has become more important in the general dynamics of the system, diminishing the effectiveness of ministerial initiatives. Perhaps one of the most typical aspects of the regulation of the Mexican health care system concerns its structure. Because the system is segmented by population group and because each segment carries out its functions independently, regulation might be said to apply autonomously within each subsystem.

The institutions in both public subsystems have similar regulatory mechanisms with respect to their relationships with doctors, because in both cases the doctors are considered to be state employees. The practices and procedures for carrying out the work come under the regulations on general work conditions. But many aspects of professional behaviour, such as prescribing, are defined by practice and are not contained in any procedural documents. Because private practice has only been explicitly incorporated into the sector in recent years, there has been no regulation of its activities. With the changes in force since the reform of social security in 1995, however, greater emphasis on regulation is expected, both in the private and the public sectors.

Possibly one of the areas of greatest regulation is the purchase of medicines by the institutions in the integrated public model. A general health council, which depends on the Secretaría de Salubridad y Asistencia (SSA, department of health), defines a basic list of medicines for the public sector and determines the purchasing mechanism. Through "consolidated purchase," as the mechanism is called, the quality and price of medicines acquired for the institutions can be controlled. The IMSS publishes an additional list of medicines, making its basic list the most complete in the country.

SECTION III.

DETERMINANTS OF UTILIZATION OF HEALTH CARE SERVICES

Chapter 8.
A Population-based Survey in Three Cities of Latin America

Enis Baris, Stella Sanchez, Mauricio de Vasconcellos, and Moises Balassiano

Introduction

This chapter focuses on health care utilization and its determinants in connection with three high priority medical conditions in Argentina, Brazil and Mexico: hypertension in adults, diarrhea in children, and prenatal care and delivery in women. Similar to other middle-income countries elsewhere in Latin America and the world, these three countries are currently undergoing an epidemiological transition characterized by both the diseases of under-development and industrialization. This population-based, condition-specific health services utilization survey was carried out in a major metropolitan area in each country. It is intended to complement the more qualitative description and analysis of the health sector reforms in the three countries under study that were given in the previous sections.[3]

While numerous researchers and theoreticians have endeavored to develop and test comprehensive theoretical models to identify the factors at play in explaining the use of health care services (Becker et al. 1977 and Cummings et al. 1980), the behavioral model of Andersen (1968) represents one multidisciplinary attempt to bring together economic, health care-related, socio-cultural, and psychological factors. The model assumes that there is a sequential relationship between three sets of determinants on which the use of services depends, namely: (1) the predisposition to use services (predisposing); (2) the ability to obtain services (enabling); and, (3) medical need. The predisposing component relates to demographic, socio-structural, and attitudinal-belief variables, irrespective of the underlying condition. The enabling component includes both family and community resource variables that are required to seek and obtain care. Finally, the need component involves an individual's perception of illness and the limitations that it imposes on daily activity and, if relevant, professional judgment.

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[3] The survey was coordinated in Argentina by Stella Sanchez, with the participation of Irene Luppi; in Brazil by Lenaura Lobato, with the participation of the PRODEMAN-UERJ (University Research Program on Social Demands, Rio de Janeiro State University); and in Mexico by Silvia Tamez, with the participation of Marco Zepeda.

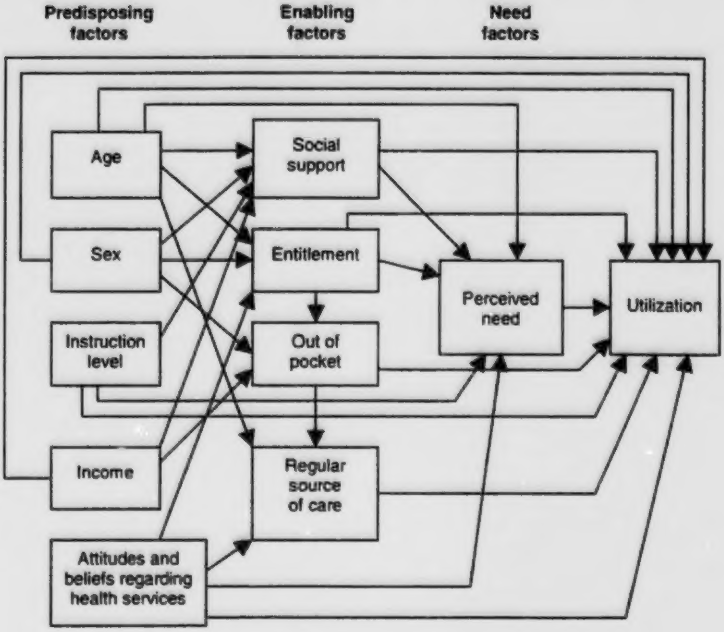
Andersen's model has been extensively used, predominantly in the North American context, to explain utilization, albeit with limited success. Need accounts for most of the explanation (Berki and Kobashigawa 1976, Wolinsky et al. 1983). Explanations for its limited explanatory power include: recall bias due to self-reported utilization; limitations of survey data as regards the type of services sought and/or received; and insufficient attention given to the purpose of the visit, site of delivery, and to provider-related variables (Mechanic 1979, Kronenfeld 1980). These issues have also been acknowledged by Andersen in a recent review of his model (Andersen 1995).

In this chapter, we will explore which factors play a predominant role in service use in Argentina, Brazil and Mexico; their relative weight vis-à-vis each other, and as groupings or components; and how such a comprehensive and empirical analysis might shed light and provide evidence for a better understanding of the health sector reform initiatives in Latin America in general. More specifically, we intend to appraise the relative importance of key enabling factors, such as insurance coverage, out-of-pocket payments, and continuity of care, which are not only mutable — and therefore sensitive to policy changes — but also tend to vary in terms of their effect on access to and use of services in times or as a consequence of health care reform.

The model: conceptual and empirical issues

The model used in this study draws heavily from Andersen's behavioral model. The predisposing factors are considered exogenous; hypothesized to influence service use both directly and indirectly through the enabling and need variables; and include age, sex, level of educational attainment, family income, and attitudes and beliefs regarding health services. The enabling factors include social support, entitlement to health coverage (health or social insurance), having a regular source of care, and out-of-pocket payment. Need for health care is expressed as "perceived need." Finally, utilization refers to the number of visits to a physician. All hypothesized causal and non-causal associations are indicated with arrows. The model is partially recursive, that is, it allows for a number of reciprocal causation or feedback loops which characterize the dynamic and ever-changing nature of the relationship between service use and health outcomes over time (See Figure 1). Appendix 1 gives the list of variables in the model and their operational definition.

Figure 1. Causal model.


Predisposing factors
Enabling factors
Need factors
Age
Sex
Instruction level
Income
Attitudes and beliefs regarding health services
Social support
Entitlement
Out of pocket
Regular source of care
Perceived need
Utilization

Sample design and study population

The Survey had a two-stage sampling design strategy. The first stage involved a two-step, self-weighted, and probabilistic household sample. The primary selection unit was the census enumeration area[4]. These areas were stratified according to socioeconomic level and selected with probabilities proportional to their size, defined as the number of private households in the area, according to the last housing and population census available for the city. The second selection unit was the household, randomly chosen from among the subset of households. First, all households were screened by means of a short questionnaire to identify those individuals with the tracer conditions. For each tracer condition a separate sub-sample of households was selected from the same sample of census enumeration areas.

Before selection, however, the census enumeration areas were stratified according to a multivariate index on the level of unmet basic needs. The index was created by the "principal components" multivariate procedure, using percentage variables indicating the number of households with a selected set of unmet needs. Using this index, three strata were defined. The first stratum included the areas with the poorest 50% of households, that is, the 50% with the highest scores on the principal factor. The second stratum included the next 30% and the third included the wealthiest 20%.

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[4] The census enumeration areas are called AGEB in Mexico City, Setor in Rio de Janeiro, and Radio in Rosario.

The field strategy was to screen the selected areas completely, to identify all individuals having at least one tracer condition, and to have them complete the appropriate questionnaires, in addition to the screening questionnaire (Kalton and Anderson 1986). While there were slight differences in the screening questionnaires used in each city, all included questions on (i) the household, itself; (ii) the number of children under 6 years of age per household; (iii) the number of females 15-49 years of age; (iv) the number of adults 30 years of age or over; (v) the number of individuals with each tracer condition per household; and (vi) the number of tracer questionnaires completed within the household.

The definitions used to identify the study populations were as follows. An individual was considered hypertensive if he or she was at least 30 years old and responded positively to the question, "Have you ever been told by a physician that you have high blood pressure?" The prenatal care study population consisted of all women between 15 to 49 years of age who had delivered during the previous 18 months. And, the diarrhea study group consisted of children under 6 years of age who had had an episode consisting of at least three liquid evacuations a day (the World Health Organization (WHO) definition of diarrhea), during the last 15 days.

Based on the data from the screening questionnaires, a sub-sample of the questionnaires for each tracer was selected to be processed and edited to provide the information needed for estimation and analysis. This field strategy reduced the cost of data collection by eliminating the need for a return to the field once the study populations with the tracer conditions had been identified, even though it involved collecting more tracer questionnaires than needed. It also made it unnecessary to resort to sample weighting, thereby avoiding the use of weighted regression analysis for non self-weighted samples.

Table 1 gives the number of areas and households by socioeconomic strata and sample city. Table 2 provides the estimated tracer-specific prevalence

Table 1. Distribution of the number of areas and households by city and sample stratum.

	Mexico City		Rio de Janeiro		Rosario	
Sample stratum	Areas	Households	Areas	Households	Areas	Households
50% poorest	2 907	896 997	3 141	779 692	397	153 712
30% intermediate	1 611	537 570	1 871	467 817	275	92 280
20% richest	1 326	359 124	1 246	311 823	186	61 707
Sum	5 844	1 793 691	6 258	1 559 332	858	307 699

rates broken down by strata and city. Table 3 provides information on the number of areas, households and individuals per tracer condition in each city.

Table 2. Prevalence rates by city, tracer, and sample stratum.

	Prevalence rates (%)								
	Mexico City			Rio de Janeiro			Rosario		
Sample stratum	Hypertension	Prenatal care	Diarrhea	Hypertension	Prenatal care	Diarrhea	Hypertension	Prenatal care	Diarrhea
50% poorest	10.1	9.3	6.4	15.6	8.2	6.0	20.0	24.4	12.3
30% intermediate	9.8	7.6	5.3	14.0	4.9	4.2	19.2	11.8	11.9
20% richest	10.6	6.4	5.9	13.1	3.4	3.8	17.4	6.8	11.4

Table 3. Number of areas, households, and individuals in the sample, by city and sample stratum.

	Mexico City			Rio de Janeiro			Rosario		
Sample stratum	Areas	Households	Individuals	Areas	Households	Individuals	Areas	Households	Individuals
Hypertension									
50% poorest	13	285	297	6	257	295	5	190	206
30% intermediate	10	150	155	3	168	191	2	123	136
20% richest	8	86	89	2	75	86	3	68	80
Sum	31	521	541	11	500	572	10	381	422
Prenatal care									
50% poorest	17	350	351	14	222	226	5	258	265
30% intermediate	12	138	139	13	106	107	2	64	64
20% richest	9	70	72	10	42	42	3	25	25
Sum	38	558	562	37	370	375	10	347	354
Diarrhea									
50% poorest	17	111	116	14	72	81	5	112	118
30% intermediate	15	48	50	13	22	25	6	59	60
20% richest	11	28	32	10	7	9	7	36	39
Sum	43	187	198	37	101	115	18	207	217

The main study questionnaires administered to those with the tracer conditions had three modules regrouping eight sets of questions, namely:

- socio-demographic characteristics (including demographic, educational, and occupational characteristics), family composition, and income;
- attitudes and beliefs regarding health services;
- social support;
- health care entitlements;
- out-of-pocket expenses;
- regular source of medical care;

- perceived need for care and perceived health (limitations and symptoms); and
- utilization of health services, in terms of the number of and reasons for visits.

In Rio de Janeiro, however, the questionnaire had one family module only to avoid repeated questioning on socio-demographic characteristics of household members, family composition, household income, and family health insurance, should there be more than one individual with a tracer condition in the household.

All questionnaires were pre-tested and validated prior to the main survey in enumeration areas other than those retained for the study. The fieldwork was carried out by local teams trained for the purpose or, in the case of Mexico, contracted out to a private firm. Prior to the survey, all interviewees were given a written document informing them of the main objectives of the survey and how the collected information would be used. They were also told that while there may not be any direct benefits to them, their participation in the survey would provide valuable input toward improving the health services. Respondents were also informed that data would be treated in a confidential manner respectful of their anonymity and confidentiality. Table 4 gives the response rate per stratum and city. Data entry and editing in all three surveys required: (i) exhaustive visual revision of all the questionnaires to verify the adequacy of the linkages between the screening questionnaire and the tracer questionnaires; (ii) coding the variables, according to code books prepared and updated during the work; (iii) entering the data into computers; and (iv) editing the data, including cross-checking the coded and entered data against the questionnaires, and verifying the consistency between the data pertaining to different variables. Although each team used different software for data entry and editing they followed the same algorithm of procedures.

Table 4. Total number of households and screening response (in households and percent), by city and sample stratum.

	Mexico City			Rio de Janeiro			Rosario		
	Number of households	Screening response		Number of households	Screening response		Number of households	Screening response	
Sample stratum		Household	%		Household	%		Household	%
50% poorest	7 295	4 141	56.8	4 705	4 064	86.4	2 966	2 748	92.7
30% intermediate	6 328	2 771	43.8	4 298	3 028	70.5	3 964	3 269	82.5
20% richest	8 329	2 597	31.2	5 643	3 516	62.3	2 613	1 810	69.3
Sum	21 952	9 509	43.3	14 646	10 608	72.4	9 543	7 827	82.0

Note: Nonresidential and unoccupied households have been excluded from the total number of households for all cities. In Rio de Janeiro, a further 1 616 households were excluded as their occupancy status could not be determined.

Statistical methods

We used path analysis to test the theoretical underpinning and the hypothesized associations in the model. Path analysis involves the use of a series of structural equations to estimate the magnitude of the hypothesized linkages between sets of variables (Alexander and Markowitz 1986). A least squares step-wise multiple regression analysis[5] was performed for each one of the endogenous variables (enabling, need, and utilization variables), including as predictors all preceding variables in the causal model, to calculate standardized partial regression coefficients (path coefficients). The standardized regression coefficient estimates the direct effect of a predictor variable on the dependent variable, controlling for the effects of all other independent variables in the equation. Since the total effect of a variable on another is the simple correlation between these two, the difference between the total effect and the direct effect yields the total indirect effect of the independent variable, that is, its effect exerted through other variables. Path coefficients thus help determine the relative importance of direct and indirect effects that predictor variables exert on the outcome variable (Johnson and Wichern 1988). As indicated in Appendix I, composite indices were created to measure attitudes and beliefs, social support, out-of-pocket payment, and perceived need. We also had to resort to either logarithmic or square-root transformation of the variables family income and number of visits because of skewed distribution (see footnotes in Tables 6-a, -b, -c for reliability scores, and skewness and kurtosis changes).

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[5] The stepwise selection of independent variables is a combination of backward and forward procedures. The first variable considered for entry into the equation is the one with the largest correlation with the dependent variable. This variable is first examined through application of the entry criterion, and then of the removal criterion. In the next step, variables not in the equation are examined for entry. After each step, variables already in the equation are examined for removal. Variables are removed until none remain that meet the removal criterion. Variable selection terminates when no more variables meet entry and removal criteria (Norusis 1986). The criteria for inclusion in and exclusion of the variables in the model were established on the basis of the probability associated to statistic *F* (0.05 and 0.10 respectively).

We also used LISREL (Bollen 1989) which allows for more flexibility in terms of assumptions than more conventional least-squares multiple regression analysis. All path diagrams in figures below display results obtained through the use of LISREL and differ only slightly from the results obtained by regression analysis.

Determinants of the Use of Health Care Services in Argentina, Brazil and Mexico

In this section, we will first present the results of the utilization survey for each country separately. Thereafter, we will have a summary discussion of the evidence from the three countries together to highlight commonalities and differences. For each country, we present below in tables and figures, and per tracer condition, the final sample sizes (Tables 5-a, -b, -c); descriptive characteristics of the study populations (Tables 6-a, -b, -c); bivariate correlation coefficients (Tables 7-a, -b, -c); findings of the path analyses (Tables 8-a, -b, -c); and, finally, in Appendix 2, path diagrams for Argentina (Figures 2-a, 3-a, 4-a), Brazil (Figures 2-b, 3-b, 4-b) and Mexico (Figures 2-c, 3-c, 4-c).

Rosario, Argentina

Table 5-a below gives the number of cases included in the analysis. The vast majority of the individuals had at least one visit to a physician during the preceding 6 months, and many had several (Table 6-a).

Table 5-a. Numbers of cases in the study — Argentina.

		Surveyed with at least one physicians' visit in the period under study	
Tracer condition	Total surveyed	Number	%
Hypertension	422	356	84.3
Prenatal care	354	350	98.9
Diarrhea	217	208	95.9

In the hypertensive group, entitlement to health coverage was positively correlated with the level of education. There was also strong correlation between attitudes and beliefs regarding health services and the importance of out-of-pocket payments for individuals on one hand, and the perceived health needs on the other (Table 7-a). Some correlation was also detected between the number of physicians' visits and perceived need, entitlement, and out-of-pocket payment valuation.

For prenatal care, the level of education has an important positive correlation both with family income and with entitlement (Table 7-a). The latter two were also highly correlated. In addition, attitudes and beliefs regarding health services were correlated with out-of-pocket money valuation. More importantly perhaps, the number of visits had the highest correlation with the level of education and income, and with entitlement.

Table 6-a. Means and standard deviations of the variables used in the model — Argentina.

Variable and categories	Mean	Standard deviation
Hypertension		
Predisposing		
Age (AGE)	62.77	14.13
Sex (SEX)	0.63	0.48
0 = male (131)		
1 = female (225)		
Education level (INS)	8.22	4.24
Family income	635.43	617.56
Log transformation (INC) (a)	2.67	0.32
Attitudes and beliefs about health services (A&B) (b)	15.35	2.59
Enabling		
Social support (SSO) (c)	13.70	6.43
Entitlement (ENT)	1.38	0.78
0 = without health coverage (43)		
1 = limited (158)		
2 = medium (132)		
3 = high (23)		
Out-of-pocket payment (OPM) (d)	3.38	0.65
Regular source of care (RSC)	0.77	0.42
0 = no particular doctor as usual source of care (82)		
1 = particular doctor as usual source of care (274)		
Need		
Perceived need (PNE) (e)	1.67	0.42
Utilization		
Number of physician visits	4.58	3.58
Square root transformation (NUM) (f)	1.99	0.77

(a) Log transformation reduced the skewness from 2.67 to 0.49 and the kurtosis from 7.73 to 0.14.
(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.65.
(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.77.
(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.77.
(e) Cronbach's alpha coefficient associated to the scale of 9 items: 0.65.
(f) Square-root transformation reduced the skewness from 2.05 to 0.64 and the kurtosis from 8.94 to 0.54.

Variable and categories	Mean	Standard deviation
Prenatal care		
Predisposing		
Age (AGE)	28.21	6.73
Education level (INS)	8.61	4.40
Family income	666.74	684.18
Log transformation (INC) (a)	2.65	0.38
Attitudes and beliefs about health services (A&B) (b)	15.87	2.34
Enabling		
Social support (SSO) (c)	10.48	3.97
Entitlement (ENT)	0.79	1.02
0 = without health coverage (207)		
1 = limited (29)		
2 = medium (93)		
3 = high (20)		
Out-of-pocket payment (OPM) (d)	3.86	0.32
Regular source of care (RSC)	0.31	0.46
0 = no particular doctor as usual source of care (240)		
1 = particular doctor as usual source of care (109)		

(continued)

Table 6-a continued.

Variable and categories	Mean	Standard deviation
Prenatal care *(continued)*		
Need		
Perceived need (PNE) (e)	1.75	0.32
Utilization		
Number of physician visits (NUM)	10.23	4.58

(a) Log transformation reduced the skewness from 2.29 to 0.18 and the kurtosis from 5.52 to -0.20.
(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.68.
(c) Cronbach's alpha coefficient associated to the scale of 5 items: 0.41.
(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.63.
(e) Cronbach's alpha coefficient associated to the scale of 11 items: 0.32.

Diarrhea		
Predisposing		
Age (AGE)	2.32	1.62
Sex (SEX)	0.42	0.49
0 = male (122)		
1 = female (86)		
Education level (INS)	9.39	4.83
Family income	843.68	898.21
Log transformation (INC) (a)	2.71	0.422
Attitudes and beliefs about health services (A&B) (b)	15.61	2.51
Enabling		
Social support (SSO) (c)	16.34	5.46
Entitlement (ENT)	1.03	1.07
0 = without health coverage (93)		
1 = limited (32)		
2 = medium (66)		
3 = high (17)		
Out-of-pocket payment (OPM) (d)	3.73	0.42
Regular source of care (RSC)	0.74	0.44
0 = no particular doctor as usual source of care (55)		
1 = particular doctor as usual source of care (153)		
Need		
Perceived need (PNE) (e)	1.88	0.36
Utilization		
Number of physician visits (NUM)	3.64	2.29

(a) Log transformation reduced the skewness score from 1.82 to 0.22 and the kurtosis from 2.57 to -0.69
(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.69.
(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.73.
(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.66.
(e) Cronbach's alpha coefficient associated to the scale of 6 items: 0.35.

For the diarrhea tracer, as for prenatal care, education had high correlation coefficients both with income and with entitlement (Table 7-a). As expected, the level of education was associated with regular source of care and with perceived need. Again, family income also correlated positively with health coverage and with perceived need. As to the number visits by the child, his or her age, perceived need-for-care, and having a regular source of care showed the highest correlations.

Table 8-a and Figures 2-a, 3-a and 4-a in Appendix 2 depict, in both tabular and diagrammatic forms, the results of the path analysis. Only statistically significant regressions, path coefficients and associations are shown. The slight differences between the coefficient values in the table and figures reflect the use of both least-squares regression and LISREL for analysis (see Footnote 2). Overall, for hypertension, the model could only explain 9% of the total variation in service use. Although this was lower than expected, it was nevertheless not surprising given the relatively lower predictive power of a behavioral model for more discretionary services. Enabling factors were the main determinants of service use, indicating the sensitivity of physician utilization to health care prices and fees, and coverage. Also noteworthy was the role of gender, social support, and attitudes and beliefs in explaining perceived need-for-care.

The model proved to be more powerful in explaining service use in relation to prenatal care (R square = 0.32). The main predictors were level of education, entitlement, social support, and age, positively, and attitudes and beliefs and out-of-pocket payments, negatively.

As to the factors impacting on the key enabling variables, both entitlement and out-of-pocket payment were explained almost solely by family income; social support by level of education and by income; and regular source of care by out-of-pocket money.

For diarrhea, use of physician services appears to be determined directly by need-for-care, by the child's age (negatively so), and by having a regular source of care. It is also noteworthy, as well as somewhat expected, that perceived need for care and consequent utilization of services was largely dependent on mother's level of education.

To synthesize, in Argentina, the model better explained service use in relation to prenatal care than in relation to diarrhea or, even less, hypertension. While enabling factors and need were the only determinants of service use for hypertensive individuals, predisposing factors were equally important in explaining use for prenatal care and diarrhea. Surprisingly, need-for-care had no bearing on service use during pregnancy. However, the fact that having a regular source of care, health care coverage, and out-of-pocket payments were among the key explanatory factors for all three tracers, indicates that health care services are not accessible to all in an equitable manner, despite the high level of education and awareness of the importance of seeking health care for the tracer conditions at under study.

Table 7-a. Correlation coefficients — Argentina.

Hypertension

	SEX	INS	INC	A&B	SSO	ENT	OPM	RSC	PNE	NUM
AGE	-0.035	-0.201	-0.118	-0.073	-0.185	-0.057	-0.143	0.227	-0.037	0.106
SEX		-0.179	0.048	0.006	0.169	-0.160	-0.052	-0.044	-0.123	0.106
INS			0.122	0.059	0.083	0.514	-0.027	0.081	0.112	-0.090
INC				0.005	0.064	0.165	0.022	-0.006	0.102	0.045
A&B					0.170	0.029	0.480	0.115	0.302	-0.042
SSO						0.161	0.002	0.227	0.235	-0.041
ENT							-0.024	0.095	0.113	0.150
OPM								0.012	0.208	-0.161
RSC									0.100	-0.009
PNE										-0.170

Prenatal care

	INS	INC	A&B	SSO	ENT	OPM	RSC	PNE	NUM
AGE	0.236	0.261	-0.001	0.077	0.253	-0.051	0.053	0.108	0.234
INS		0.647	-0.112	0.260	0.721	-0.213	0.259	0.288	0.462
INC			-0.093	0.249	0.688	-0.196	0.220	0.209	0.378
A&B				0.117	-0.076	0.358	-0.078	0.005	-0.269
SSO					0.218	-0.017	0.113	0.171	0.222
ENT						-0.158	0.219	0.247	0.420
OPM							-0.146	-0.052	-0.277
RSC								0.071	0.153
PNE									0.159

Diarrhea

	SEX	INS	INC	A&B	SSO	ENT	OPM	RSC	PNE	NUM
AGE	-0.065	0.015	0.034	-0.006	0.014	-0.018	0.095	-0.170	0.086	-0.262
SEX		-0.006	-0.018	-0.089	-0.112	-0.018	0.010	-0.006	-0.019	-0.079
INS			0.700	-0.077	0.214	0.697	-0.169	0.380	0.340	-0.095
INC				-0.056	0.229	0.722	-0.164	0.285	0.375	-0.094
A&B					-0.058	-0.021	0.349	0.053	0.017	0.114
SSO						0.156	-0.172	0.168	0.174	0.017
ENT							-0.107	0.333	0.329	-0.041
OPM								-0.080	-0.074	-0.053
RSC									0.089	0.185
PNE										-0.255

Table 8-a. Variance explained and partial regression coefficients — Argentina.

Dependent variable	R² (variance explained)	Independent variable	Standardized partial regression coefficient
Tracer hypertension			
Utilization			
Number of physician visits (NUM)	0.09	Entitlement (ENT)	0.14
		Out-of-pocket payment (OPM)	–0.14
		Perceived need (PNE)	–0.13
Need			
Perceived need (PNE)	0.15	Attitudes and beliefs (A&B)	0.27
		Social support (SSO)	0.21
		Sex (SEX)	–0.16
Enabling			
Regular source of care (RSC)	0.07	Age (AGE)	0.24
Out-of-pocket payment (OPM)	–	Attitudes and beliefs (A&B)	0.13
Entitlement (ENT)	0.06	Income (INC)	0.17
Social support (SSO)	0.06	Age (AGE)	–0.17
		Sex (SEX)	0.16
		Age (AGE)	–0.18
Tracer prenatal care			
Utilization			
Number of physician visits (NUM)	0.32	Education level (INS)	0.24
		Attitudes and beliefs (A&B)	–0.20
		Entitlement (ENT)	0.15
		Social support (SSO)	–0.14
		Out-of-pocket payment (OPM)	–0.12
		Age (AGE)	0.12
Need			
Perceived need (PNE)	0.08	Education level (INS)	0.29
Enabling			
Regular source of care (RSC)	0.02	Out-of-pocket payment (OPM)	–0.15
Out-of-pocket payment (OPM)	0.04	Income (INC)	0.20
Entitlement (ENT)	0.47	Income (INC)	0.69
Social support (SSO)	0.08	Education level (INS)	0.17
		Income (INC)	0.14
Tracer diarrhea			
Utilization			
Number of physician visits (NUM)	0.15	Perceived need (PNE)	–0.25
		Regular source of care (RSC)	0.17
		Age (AGE)	–0.21
Need			
Perceived need (PNE)	0.12	Education level (INS)	0.34
Enabling			
Regular source of care (RSC)	0.24	Age (AGE)	–0.17
Out-of-pocket payment (OPM)	0.03	Income (INC)	–0.16
Entitlement (ENT)	0.52	Income (INC)	0.72
Social support (SSO)	0.05	Income (INC)	0.23

Rio de Janeiro, Brazil

As in Rosario, a large majority of individuals with the tracer conditions under study visited a physician at least once during the 6-month period preceding the survey (Tables 5-b and 6-b). We observed high degrees of correlation between income, education, and entitlement irrespective of the tracer condition (Table 7-b).

Table 5-b. Numbers of cases in the study — Brazil.

Tracer condition	Total surveyed	Surveyed with at least one physicians' visit in the period under study	
		Number	%
Hypertension	572	492	86.0
Prenatal care	375	367	95.3
Diarrhea	115	103	89.6

Table 6-b. Means and standard deviations of the variables used in the model — Brazil.

Variable and categories	Mean	Standard deviation
Hypertension		
Predisposing		
Age (AGE)	58.98	13.59
Sex (SEX)	1.67	0.47
1 = male (197)		
2 = female (295)		
Education level (INS)	7.28	4.55
Family income (INC)	1364.68	1508.14
Square-root transformation (SQINCOME) (a)	32.81	16.80
Attitudes and beliefs about health services (A&B) (b)	11.83	5.64
Enabling		
Social support (SSO) (c)	15.38	3.60
Entitlement (ENT) (d)	7.96	3.28
Out-of-pocket payment (OPM) (e)	25.65	5.20
Regular source of care (RSC)	0.61	0.49
0 = no particular doctor as usual source of care (192)		
1 = particular doctor as usual source of care (300)		
Need		
Perceived need (PNE) (f)	2.04	0.53
Utilization		
Number of physician visits (NUM)	2.49	2.92
Square root transformation (SQCONSUL) (g)	0.61	1.60
Log transformation (LGCONSUL) (h)	0.81	0.70

(a) Square-root transformation reduced the skewness from 2.78 to 1.20 and the kurtosis from 10.43 to 1.90.

(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.91.

(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.47.

(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.95.

(e) Cronbach's alpha coefficient associated to the scale of 4 items: 0.75.

(f) Cronbach's alpha coefficient associated to the scale of 9 items: 0.76.

(g) Square-root transformation reduced the skewness from 2.70 to 1.27 and the kurtosis from 11.35 to 2.22.

(h) Log transformation reduced the skewness from 2.70 to 0.43 and the kurtosis from 11.35 to –0.60.

(continued)

Table 6-b continued.

Variable and Categories	Mean	Standard deviation
Prenatal care		
Predisposing		
Age (AGE)	26.31	6.59
Education level (INS)	8.65	3.43
Family income (INC)	1070.65	1400.03
Square-root transformation (SQINCOME) (a)	1.90	7.98
Attitudes and beliefs about health services (A&B) (b)	11.81	5.49
Enabling		
Social support (SSO) (c)	17.17	4.66
Entitlement (ENT) (d)	7.25	3.21
Out-of-pocket payment (OPM) (e)	26.72	5.37
Regular source of care (RSC)	0.45	0.50
0 = no particular doctor as usual source of care (165)		
1 = particular doctor as usual source of care (201)		
Need		
Perceived need (PNE) (f)	2.38	0.43
Utilization		
Number of physician visits (NUM)	10.80	5.72
Square root transformation (SQCONSUL) (g)	3.18	0.79
Log transformation (LGCONSUL) (h)	2.56	0.51

(a) Square-root transformation reduced the skewness from 6.70 to 1.90 and the kurtosis from 75.51 to 7.98.
(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.90.
(c) Cronbach's alpha coefficient associated to the scale of 5 items: 0.75.
(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.96.
(e) Cronbach's alpha coefficient associated to the scale of 4 items: 0.77.
(f) Cronbach's alpha coefficient associated to the scale of 11 items: 0.71.
(g) Square-root transformation reduced the skewness from 2.29 to 0.82 and the kurtosis from 10.22 to 2.71.
(h) Log transformation reduced the skewness from 2.29 to –0.63 and the kurtosis from 10.22 to 2.63.

Variable and Categories	Mean	Standard deviation
Diarrhea		
Predisposing		
Age (AGE)	1.92	1.61
Sex (SEX)	1.42	0.50
1 = male (43); 2=female (60)		
Education level of the mother (INC)	7.88	3.24
Family income (INC)	761.21	748.56
Square-root log transformation (SQINCOME) (a)	25.21	11.26
Attitudes and beliefs about health services (A&B) (b)	10.40	5.54
Enabling		
Social support (SSO) (c)	16.82	4.59
Entitlement (ENT) (d)	6.80	3.28
Out-of-pocket payment (OPM) (e)	26.39	4.60
Regular source of care (RSC)	0.54	0.50
0 = no particular doctor as usual source of care (55)		
1 = particular doctor as usual source of care (48)		
Need		
Perceived need (PNE) (f)	2.32	0.46
Utilization		
Number of physician visits (NUM)	3.74	3.34
Square root transformation (SQCONSUL) (g)	2.00	0.75
Log transformation (LGCONSUL) (h)	1.00	0.78

(a) Square-root transformation reduced the skewness from 2.65 to 1.23 and the kurtosis from 8.77 to 2.18.
(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.87.
(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.75.
(d) Cronbach's alpha coefficient associated to the scale of 4 items: 0.96.
(e) Cronbach's alpha coefficient associated to the scale of 6 items: 0.82.
(f) Cronbach's alpha coefficient associated to the scale of 4 items: 0.67.
(g) Square-root transformation reduced the skewness from 1.86 to 1.07 and the kurtosis from 3.64 to 0.61.
(h) Log transformation reduced the skewness from 1.86 to 0.38 and the kurtosis from 3.64 to –0.79.

Table 7-b. Correlation coefficients — Brazil.

Hyper-tension	SSO	ENT	OPM	PNE	NUM	AGE	SEX	INS	INC	A&B
SSO	1.000									
ENT	0.017	1.000								
OPM	0.003	0.030	1.000							
PNE	0.071	0.191	0.141	1.000						
LGCONSUL	0.003	0.164	-0.082	-0.066	1.000					
AGE	-0.059	0.183	-0.098	0.159	-0.002	1.000				
SEX	0.033	-0.062	0.024	-0.029	0.020	0.016	1.000			
INS	0.022	0.363	0.059	0.244	0.063	-0.065	-0.230	1.000		
SQINCOME	0.013	0.467	0.005	0.175	0.043	0.141	-0.213	0.461	1.000	
A&B	-0.126	0.231	0.205	0.099	0.061	0.126	-0.006	0.131	0.201	1.000

Prenatal care	SSO	ENT	OPM	RSC	PNE	NUM	AGE	INS	INC	A&B
SSO	1.000									
ENT	0.098	1.000								
OPM	-0.108	0.131	1.000							
RSC	-0.017	0.302	0.067	1.000						
PNE	0.016	0.143	0.194	-0.031	1.000					
LGCONSUL	0.127	0.279	-0.068	0.237	0.009	1.000				
AGE	0.026	0.154	-0.074	0.096	0.055	0.133	1.000			
INS	0.191	0.530	-0.078	0.252	0.172	0.370	0.300	1.000		
LGINCOME	0.061	0.365	-0.004	0.114	0.208	0.190	0.091	0.450	1.000	
A&B	0.121	0.183	0.082	0.065	0.067	0.052	0.018	0.108	0.129	1.000

Diarrhea	(SSO)	(ENT)	(OPM)	(RSC)	(PNE)	(NUM)	(AGE)	(SEX)	(INS)	(INC)	(A&B)
SSO	1.000										
ENT	0.020	1.000									
OPM	-0.129	-0.014	1.000								
RSC	-0.065	0.397	-0.212	1.000							
PNE	0.063	0.069	0.123	0.000	1.000						
LGCONSUL	-0.077	0.091	-0.300	0.120	-0.099	1.000					
AGE	0.001	0.012	0.198	-0.044	-0.229	-0.416	1.000				
SEX	-0.050	-0.074	-0.175	0.143	-0.014	0.045	-0.118	1.000			
INS	0.201	0.391	-0.291	0.267	0.114	0.159	-0.074	-0.043	1.000		
LGINCOME	0.100	0.387	-0.029	0.151	0.246	-0.016	-0.050	-0.108	0.458	1.000	
A&B	-0.169	0.143	0.162	0.067	0.037	0.134	-0.130	0.130	-0.096	-0.016	1.000

Table 8-b gives the results of the path analyses. For hypertension, the amount of variation in service use that is explained by the model remained very low, at 6.87 percent of the total variation. Moreover, none of the predisposing variables was included in the final model which contained only regular source of care and entitlement as enabling variables, in addition to perceived need. The latter, in its turn, was mainly explained by age, sex, out-of-pocket payment, and having a regular source of care.

In the case of prenatal care, the fitted model fared much better, and explained 15.9 percent of the total variation in physician utilization, education and having regular source of care being the main explanatory factors. Income, attitudes and beliefs influenced women's perception of need-for-care, along with out-of-pocket payment and having a regular source of care.

Table 8-b. Path analysis coefficients — Brazil.

Variable	R^2 (variance explained)	Independent variable	Standardized partial regression coefficient
Hypertension			
Utilization variables			
Number of visits to doctor (NUM)*	0.0687	Perceived need (PNE)	-0.1108
		Regular source of care (RSC)	0.2201
		Entitlement (ENT)	0.1058
Need variables			
Perceived need (PNE)	0.0916	Education (INS)	0.2558
		Age (AGE)	0.1769
Enabling variables			
Regular source of care (RSC)	0.0002	Attitudes & beliefs (A&B)	-0.0607
Entitlement (ENT)	0.2483	Sqincome (INC)	0.4254
		Attitudes & beliefs (A&B)	0.1321
		Age (AGE)	0.1070
* Log transformation of number of visits to the doctor.			
Prenatal care			
Utilization variables			
Number of visits to doctor (NUM)*	0.1590	Education level (INS)	0.3322
		Regular source of care (RSC)	0.1716
Need variables			
Perceived need (PNE)	0.0294	Education level (INS)	0.1723
Enabling variables			
Regular source of care (RSC)	—		
Out-of-pocket payment (OPM)	0.0171	Entitlement (ENT)	0.1307
Entitlement (ENT)	0.2373	Sqincome (INC)	0.4319
		Age (AGE)	0.1002
		Attitudes & beliefs (A&B)	0.1310
Social support (SSO)	0.0366	Education level (INS)	0.1914
* Log transformation of number of visits to the doctor.			
Diarrhea			
Utilization variables			
Number of visits to doctor (NUM)*	0.2309	Age (AGE)	-0.3709
		Out-of-pocket payment (OPM)	-0.2501
Need variables			
Perceived need (PNE)	0.0452	Age (AGE)	-0.2135
Enabling variables			
Regular source of care (RSC)	0.0001	Out-of-pocket payment (OPM)	0.2393
Entitlement (ENT)	0.1498	Logincome (INC)	0.3881
Social support (SSO)	0.0404	Education level (INS)	0.2009
* Log transformation of number of visits to the doctor.			

As for diarrhea, the amount of the total variation explained was much higher, that is, 25%. Service use was, as expected, determined by the age of the child, out-of-pocket payment, and perceived need, the latter being itself influenced by age of child, out-of-pocket payment, and income.

In summary, the model's predictive power was low overall and across the three tracer conditions. Nevertheless, enabling variables, especially having a regular source of care and health coverage, proved to be the main variables influencing service use. Surprisingly, perceived need had no bearing on service use in pregnancy, but having a regular source of care had. The effect of predisposing factors was negligible, except for the age of the child in case of diarrhea, and the level of education in seeking and using prenatal care.

Mexico City, Mexico

The proportion of individuals who had at least one visit to a physician, and the average number of visits during the 6 months preceding the survey were, in general, slightly higher compared with the study populations in Argentina and Brazil, except for prenatal care (Tables 5-c and 6-c). In the hypertension group, it was noteworthy that there were positive correlations between schooling and social support, and that attitudes and beliefs correlated positively with both direct out-of-pocket payment and perceived need. In addition, service use was positively correlated, albeit to a lesser extent, with income, attitudes and beliefs, social support, entitlement, and having a regular source of care.

In the case of prenatal care, similar correlations were found between schooling, social support, and income, and service use, and between attitudes and beliefs and out-of-pocket payment. The variables with the highest correlation with service use were schooling, income, social support, and perceived need.

As expected in the case of diarrhea, age was negatively with service use. In turn, there were positive correlations between schooling and both income and social support; between income, and entitlement and perceived need; and between attitudes and beliefs, and both direct payment and regular source of care (Table 7-c).

The results of path analyses are shown in Table 8-c and in Figures 4-a, 4-b and 4-c in Appendix 2. In the case of arterial hypertension, all the variables in the model were found to have a direct or indirect effect on utilization, although the proportion of the variance explained was very low, about 10%. The main factors that had a direct effect were perceived need, entitlement, direct payment, social support, and attitudes and beliefs. In addition to the direct effects, the main indirect effects included age, sex, attitudes and beliefs, and social support through perceived need.

Table 5-c. Numbers of cases in the study — Mexico.

Tracer condition	Total surveyed	Surveyed with at least one physicians' visit in the period under study	
		Number	%
Hypertension	541	514	95.0
Prenatal care	562	544	96.8
Diarrhea	198	192	97.0

In the case of prenatal care, the model did not fare any better. Contrary to observations in the other two countries, income, education, and social support were the main explanatory variables and, to a lesser extent, out-of-pocket payment and perceived need.

As for diarrhea, the main variable with direct influence was the age of the child, although more variables were found to have a significant effect on service use when LISREL was used (see Figure 4-c in Appendix 2), resulting in a slight increase in the proportion of the total variation explained.

Table 6-c. Means and standard deviations of variables used in the model — Mexico.

Variable and categories	Mean	Standard deviation
Hypertension		
Predisposing variables		
Age (AGE)	58.00	13.36
Sex (SEX)	0.80	0.40
0 = male (109)		
1 = female (432)		
Education level (INS)	6.25	4.40
Family income (INC)	478.36	405.73
Log transformation of income (LGINCOME) (a)	5.89	0.75
Attitudes and beliefs (A&B) (b)	12.05	5.04
Enabling variables		
Social support (SSO) (c)	15.35	4.94
Entitlement (ENT)	0.92	0.26
0 = without entitlement (41)		
1 = with entitlement (500)		
Out-of-pocket payment (OPM) (d)	2.40	1.06
Regular source of care (RSC)	0.51	0.50
0 = without regular doctor (267)		
1 = with regular doctor (274)		
Need variables		
Perceived need (PNE)	1.61	0.50
Utilization variables		
Number of visits to doctor (NUM)	5.58	6.09
Log transformation of use (LGCONSUL) (e)	1.42	0.75

(a) Log transformation reduced the skewness from 2.74 to 0.08 and the kurtosis value from 9.83 to 0.11.

(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.86.

(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.71.

(d) Cronbach's alpha coefficient associated to the scale of 2 items: 0.84.

(e) Log transformation reduced the skewness from 5.92 to 0.12 and the kurtosis value from 53.93 to 0.50.

(continued)

Table 6-c continued.

Variable and Categories	Mean	Standard deviation
Prenatal care		
Predisposing variables		
Age (AGE)	25.94	5.92
Education level (INS)	9.52	3.50
Family income (INC)	454.90	381.57
Log transformation of income (LGINCOME) (a)	5.85	0.73
Attitudes and beliefs (A&B) (b)	11.30	4.77
Enabling variables		
Social support (SSO) (c)	16.58	4.04
Entitlement (ENT)	0.83	0.38
0 = without entitlement (95)		
1 = with entitlement (467)		
Out-of-pocket payment (OPM) (d)	2.19	0.95
Regular source of care (RSC)	0.53	0.50
0 = without regular doctor (266)		
1 = with regular doctor (296)		
Need variables		
Perceived need (PNE)	1.86	0.44
Utilization variables		
Number of visits to doctor (NUM)	6.67	4.13
Square-root transformation of use (SQCONSUL) (e)	2.41	0.93

(a) Log transformation reduced the skewness from 2.69 to -0.01 and the kurtosis value from 9.70 to 0.14.

(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.83.

(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.64.

(d) Cronbach's alpha coefficient associated to the scale of 2 items: 0.66.

(e) The square root transformation reduced skewness from 1.29 to -0.74 and the kurtosis value from 3.87 to 1.64.

Diarrhea		
Predisposing variables		
Age (AGE)	2.29	1.60
Sex (SEX)	0.44	0.50
0 = male (111)		
1 = female (87)		
Education level (INS)	8.43	3.62
Family income (INC)	495.47	443.92
Log transformation of income (LGINCOME) (a)	5.90	0.76
Attitudes and beliefs (A&B) (b)	11.50	4.57
Enabling variables		
Social support (SSO) (c)	16.57	4.27
Entitlement (ENT)	0.84	0.37
0 = without entitlement (32)		
1 = with entitlement (166)		
Out-of-pocket payment (OPM) (d)	2.03	0.93
Regular source of care (RSC)	0.67	0.47
0 = without regular doctor (65)		
1 = with regular doctor (133)		
Need variables		
Perceived need (PNE)	1.82	0.47
Utilization variables		
Number of visits to doctor (NUM)	3.15	2.73
Log transformation of use (LGCONSUL) (e)	0.88	0.71

(a) Log transformation reduced the skewness from 2.55 to 0.07 and the kurtosis value from 7.64 to 0.13.

(b) Cronbach's alpha coefficient associated to the scale of 9 items: 0.80.

(c) Cronbach's alpha coefficient associated to the scale of 6 items: 0.63.

(d) Cronbach's alpha coefficient associated to the scale of 2 items: 0.72.

(e) The log transformation reduced the skewness from 3.23 to 0.36 and the kurtosis value from 18.39 to -0.50.

In summary, except for regular source of care, enabling factors were the main explanatory variables in all three models. Education, income, and attitudes and beliefs also played a secondary role in directly influencing service use, whereas age was the key factor in the case of diarrhea.

Table 7-c. Correlation coefficients — Mexico.

Hyper-tension	Sex (SEX)	Edu-cation (INS)	Log-income (INC)	Attitudes (A&B)	Support (SSO)	Entitle-ment (ENT)	Pay-ment (OPM)	Source (RSC)	Need (PNE)	Loguse (NUM)
AGE	-0.2345	-0.2963	-0.0867	0.2085	-0.1066	0.1988	0.1531	-0.0053	0.1582	0.0761
SEX		-0.1705	-0.0307	-0.0798	0.0009	-0.0754	-0.0597	0.0113	-0.1651	-0.0331
INS			0.3175	0.0315	0.2205	0.0155	-0.0042	0.0302	0.1510	0.0161
INC				0.0301	0.1259	0.1111	0.0000	0.0508	0.0778	0.1159
A&B					0.0621	0.0912	0.4060	0.0087	0.2646	0.1732
SSO						-0.0294	-0.0003	-0.0194	0.1260	0.1093
ENT							0.1023	0.0287	0.1193	0.1078
OPM								-0.1135	0.1925	-0.0482
RSC									-0.0513	0.1000
PNE										-0.1004

Prenatal Care	Sex (SEX)	Edu-cation (INS)	Log-income (INC)	Attitudes (A&B)	Support (SSO)	Entitle-ment (ENT)	Pay-ment (OPM)	Source (RSC)	Need (PNE)	Sqrtuse (NUM)
AGE		0.1327	0.1504	-0.0224	0.0819	0.1182	0.0461	0.0261	-0.1089	0.0482
INS			0.3683	0.1005	0.3387	0.0530	0.0348	0.1349	0.0642	0.2437
INC				0.1653	0.1695	0.1705	0.1275	-0.0030	0.1155	0.2203
A&B					0.1382	0.0385	0.2186	0.1109	0.1420	0.0615
SSO						0.0653	-0.0572	0.0679	0.0505	0.2429
ENT							0.1021	-0.0491	0.1339	0.0215
OPM								-0.0899	0.0841	-0.0692
RSC									0.0777	0.0959
PNE										0.1094

Diar-rhea	Sex (SEX)	Edu-cation (INS)	Log-income (INC)	Attitudes (A&B)	Support (SSO)	Entitle-ment. (ENT)	Pay-ment (OPM)	Source (RSC)	Need (PNE)	Loguse (NUM)
AGE	-0.1079	-0.2162	-0.0453	-0.0467	-0.0754	0.0389	0.0947	-0.0311	-0.1421	-0.2936
SEX		-0.1397	-0.0905	-0.0938	-0.1228	-0.0443	-0.1362	-0.1715	-0.0178	0.0429
ENS			0.2688	0.1452	0.1985	-0.0072	0.0462	0.1199	0.1845	0.0673
INC				-0.0005	0.1697	0.1698	0.0537	-0.0541	0.2355	-0.0022
A&B					0.1658	-0.0079	0.3800	0.2702	0.1098	-0.0413
SSO						0.0744	-0.0768	0.2188	0.0478	0.0876
ENT							-0.0165	-0.0757	0.0387	0.0398
OPM								-0.0395	0.2704	-0.0638
RSC									-0.0396	0.0243
PNE										-0.0258

Table 8-c. Path analysis coefficients — Mexico.

Variable	R^2 (variance explained)	Independent variable	Standardized partial regression coefficient
Hypertension			
Utilization variables			
Number of visits to doctor (NUM)*	0.1025	Perceived need (PNE)	-0.1598
		Out-of-pocket payment (OPM)	-0.1169
		Entitlement (ENT)	0.1058
		Social support (SSO)	0.1013
		Attitudes and beliefs (A&B)	0.2331
		Logincome (INC)	0.0877
Need variables			
Perceived need (PNE)	0.1267	Social support (SSO)	0.1170
		Attitudes and beliefs (A&B)	0.2376
		Education (INS)	0.1664
		Age (AGE)	0.1583
Enabling variables			
Regular source of care (RSC)	0.0116	Out-of-pocket payment (OPM)	-0.1085
Out-of-pocket payment (OPM)	0.0105	Entitlement (ENT)	0.1064
Entitlement (ENT)	0.0561	Logincome (INC)	0.1241
		Age (AGE)	0.2004
Social support (SSO)	0.0486	Education level (INS)	0.2116
* Log transformation of number of visits to the doctor.			
Prenatal care			
Utilization variables			
Number of visits to doctor (NUM)*	0.1041	Social support (SSO)	0.1250
		Logincome (INC)	0.0999
		Education level (INS)	0.0993
Need variables			
Perceived need (PNE)	0.0309	Attitudes and beliefs (A&B)	0.1455
		Age (AGE)	-0.0970
Enabling variables			
Regular source of care (RSC)	0.0267	Direct payment (OPM)	-0.1150
		Attitudes and beliefs (A&B)	0.1445
Out-of-pocket payment (OPM)	0.0163	Logincome (INC)	0.1289
Entitlement (ENT)	0.0378	Logincome (INC)	0.1532
		Age (AGE)	0.0920
Social support (SSO)	0.1147	Education level (INS)	0.3502
* Square-root transformation of number of visits to the doctor.			
Diarrhea			
Utilization variables			
Number of visits to the doctor (NUM)*	0.0862	Age (AGE)	-0.2919
Need variables			
Perceived need (PNE)	0.0340	Education level (INS)	0.1871
Enabling variables			
Regular source of care (RSC)	0.1001	Out-of-pocket payment (OPM)	-0.1677
		Attitudes and beliefs (A&B)	0.3382
Out-of-pocket payment (OPM)	–	–	–
Entitlement (ENT)	0.0288	Logincome (INC)	0.1757
Social support (SSO)	0.0394	Education level (INS)	0.2094
* Log transformation of number of visits to the doctor.			

Discussion

According to Andersen and many others, access to health care is equitable to the extent that the "need" variables account for a large proportion of variations in service use (Andersen 1968). Service use may take different forms, depending upon its type, i.e., discretionary or non-discretionary; its purpose, i.e., preventive vs. curative; the place of service delivery, i.e., out-patient clinic vs. hospital care; or its nature, i.e., physician visits vs. dental etc. In this study we tried to cover a large spectrum of health care needs by selecting three distinct tracer conditions in terms of their nature, and the type and purpose of the services they will require, so as to be able to better understand the relative role of the enabling and need variables in times of health care reform. Obviously, such a study has its own limitations, not the least being its cross-sectional nature which does not allow for clearly differentiating causes from effects. Moreover, and more importantly perhaps, is the limitation in observing or measuring the trends, and hence the changes in the relative role of a number of key variables like income and entitlement over time, as reforms evolve or get implemented.

While Andersen's model has so far been unable to explain a large proportion of the variation in service use in developed countries, we thought that it might prove to have a higher explanatory power in the health care context of higher middle-income countries such as Argentina, Brazil and Mexico. In these countries, availability of health care services has ceased to be an issue while accessibility — or more importantly, affordability — remains a major concern. While the model did not prove to be more powerful, the findings nevertheless concur with the observations made in the previous chapters with respect to the lack of equity in access to care.

A number of caveats of a methodological nature are in order. First, because the original model in Figure 1 did not fit the data, an exploratory data analysis was conducted to seek the best model capable of explaining the utilization of the health services for the three tracers across the three countries. In order to find the best model for each tracer, a heuristic model was defined based on a number of statistical considerations: (i) a path entered the model whenever it was significant at 10% level; (ii) the p-value of the Minimum Fit Function Chi Square test was maximized; and, (iii) the model needed to be considered be non-recursive and observe the sequential nature of Andersen's original model.

Second, there were measurement issues related to multi-dimensional constructs as described in Appendix I. Several constructs had either low or moderate internal consistency scores (Cronbach's alpha). Third, several key variables, including income and the number of visits did not distribute normally, therefore requiring either logarithmic or square-root transformations. This was especially problematic, statistically speaking, for the dependent variable, number of visits. Fourth, regular source of care and entitlement, in the case of Mexico, were measured as dummy variables on a dichotomous scale. This may violate the assumptions behind the use of regression analysis, especially if the split between the two categories are not in the order of 0.25/0.75, as was the case in Mexico for entitlement. Finally, although originally intended, as evident in the sampling strategy selected (see above), we decided against presenting the findings per income strata. While sub-group analysis could have enriched our understanding of the main determinants of service use, it would have rendered our findings more unstable, statistically speaking, because of the reduced sample size, without, in our opinion, necessarily much affecting the overall predictive power of the underlying model.

Hypertension

In all three countries the predictive power of the model was the lowest for hypertension. This was somewhat to be expected given the nature of the condition and the consequent discretionary use of services for its management, especially in middle-income countries where it is yet to be recognized as a major health problem with severe health consequences. The results indicate that enabling variables rather than perceived need play a more prominent role in service use, which suggests lack of equity in access to health care. In addition, the effect of the key predisposing factors such as income, education, and attitudes and beliefs on utilization — which were highly correlated with one another — exerted through entitlement and out-of-pocket payment also points toward the same conclusion.

In Argentina, entitlement and out-of-pocket payment directly influenced the number of visits. Entitlement had a negative effect, however, implying that a better situation of entitlement corresponds to a lower number of office visits. Since in this country survey, entitlement was measured on a scale with the highest value meaning better quality and more coverage, the direction of the association suggests inequity in access to care. In Brazil and Mexico, the interpretation is similar, although the results are positive because of the measurement of entitlement as a dummy variable, where 1 indicated the existence of health insurance and 0 its absence. In all these countries, health care coverage does not necessarily mean access to better quality and a larger range of services but, rather, easier access to a physician. In fact, the observed direct effect of the enabling variable regular source of care on the number of visits in Brazil is a case in point.

The direct and negative effect of the enabling variable, out-of-pocket money, on the number of visits in Argentina and Mexico is revealing: the higher the costs associated with service use are perceived, the more the services are used. Although, this may seem at first to be contradictory, it was not unexpected. As the poor and the indigent tend to have poorer health than the rich, they are often obliged to allocate a larger portion of their disposable income to health care at the expense of other needs.

Prenatal care

With respect to this tracer, the three countries showed similar results, not only in terms of the proportion of service use variation explained by the model — as high as 32% in Argentina and as low as 11% in Mexico — but also in terms of the key explanatory variables. For instance, perceived need was not significantly associated with service use in Argentina and Brazil, nor was having a regular source of care significantly associated with service use in Argentina or Mexico. Moreover, in Brazil, out-of-pocket payment did not appear to have any direct or indirect effect on service use, either through perceived need or regular source of care. The same applies to entitlement, which was associated with service use only in Argentina. It seems that in Brazil, being educated and having a regular source of care are the main explanatory factors. Indeed, level of education was the only common predictor in the three countries, influencing prenatal care use directly or indirectly, through social support in Mexico and regular source of care in Brazil.

Finally, the only direct effect of income was observed in Mexico, although it exerted an indirect effect through entitlement in Argentina and Mexico. These differences may be due to a somewhat similar health care financing and delivery system in Argentina and Mexico that differs from that in Brazil. In Brazil, the social network of formal and informal connections with providers, or at least with those in the public health care system, and the fact that health care is less tiered could explain why income does not appear to be a predictor of service use, especially since the advent of the unified health model (SUS). This interpretation is more likely to reflect the reality for prenatal care and delivery than for curative and less discretionary services. For instance, the average number of prenatal care visits in Brazil was about 10, higher than in Mexico and about the same as in Argentina.

Diarrhea

Again, there were differences between the three countries in terms of the total amount of variation in service use explained, which ranged from a high of 25% in Brazil to a low of 13% in Mexico. There were also differences in the nature of the main predictors, except for the most significant one, age. The level of education of the mother, having a regular source of care, and perceived need proved to be other key predictors in Argentina. In Brazil and Mexico, the effect of out-of-pocket payment, both directly and indirectly through perceived need, was considerable. Mexico was unique in that social support and attitudes and beliefs had a direct influence on service use.

Based on these results, one could argue that, at least for this tracer, the health care system may be more equitable in Argentina than in Brazil or in Mexico. Indeed, Argentina appears to offer, in our opinion, the best primary health care of the three countries. As for the Brazil and Mexico, the findings are disconcerting because of the association between out-of-pocket payment and service use considering the characteristics of this tracer and the fact that it is relatively simple to manage. The seemingly significant dependence on the ability to pay to access to services for diarrhea can be considered indicative of inherent inequality of the health care system. Moreover, in Mexico City, out-of-pocket money is also directly influenced by social support and directly influences the existence of a regular source of care. The converse effect of out-of-pocket payment on the number of visits in Brazil could be explained by either the different nature of the measurement of this concept, which focused on the self-assessed expected costs rather than real costs, or the health seeking behavior of the poor, who might take the child to a physician in anticipation of higher costs in case of delayed diagnosis and treatment.

Another important observation, in our opinion, is the high degree of correlation between education and/or income and entitlement, especially in Argentina, considering that all three countries have adopted heath care reforms with privatization of health care delivery and financing as one of their main features.

We believe that the results are consistent with observations in previous chapters in that the health care systems in all three countries do not appear to be equitable for meeting all types of health care needs. However, based on these findings, we are not in a position to claim that that they have become more or less equitable as a consequence of health care reforms in the works in these countries. On the other hand, one could consider this study as a baseline for future studies to monitor changes in the relative importance of key variables such as income, entitlement, and having a regular source of care, and thus gauge the evolution and effects of the privatization of health care financing and delivery in Argentina, Brazil and Mexico.

Appendix 1. Operational Definitions of the Variables in the Model

Variable	Operational definition
Age (AGE)	Age of the tracer bearer at the time of survey measured in years.
Sex (SEX)	Self-explanatory: a dummy variable with 0 = male, 1 = female.
Education (INS)	Number of years formal schooling completed.
Family income (INC)	Total family income adjusted for purchasing power parity using the McDonald's index. For a given country, it is the ratio of the price of a hamburger in local currency to the price of a hamburger in US dollars.[6]
Attitudes and beliefs (A&B)	Attitudes and beliefs regarding health services calculated using an additive scale based on nine attributes regarding economic, organizational, or administrative barriers to services use. The range of the scale is from 0 to 18, with higher values corresponding to less perceived barrier.
Social support (SSO)	A social support index was created including: i. social integration, referring to the number of contacts with family members and friends; ii. sense of confidence in social contacts, expressed by the frequency with which the individual can share his or her everyday experiences, problems and feelings; and iii. degree of satisfaction with the care received, both in general and with respect to the tracer condition in particular.

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[6] In the case of Argentina, the index could not be used because of refusal by most interviewees to give information on income. Therefore, 55 individuals (13.0%) interviewed for hypertension; 36 (10.2%) for pregnancy; and 18 (8.3%) for diarrhea were classified according to socioeconomic strata as defined for the sampling design (low, medium, and high). Within each stratum, further sub-categorization was made according to individuals' health coverage. Coverage availability was divided into two categories (scarce or limited, and medium or high), imputing in the low and medium socioeconomic strata the percentile and the median of the respective income frequency distribution; in the high stratum the median and the 90th percentile (this latter imputation seeks to take into account the well-known income under-evaluation by individuals in higher socioeconomic positions).

Entitlement (ENT)	Defined differently in each country for reasons of different forms of coverage. In Argentina, quality of care received and risks related to health coverage are used as proxy to real entitlement. It is measured on an ordinal scale ranging from 0 to 3, with the lower value indicating a situation of less coverage.[7] Brazil and Mexico used a dummy variable, in which 0 signified the absence of private health insurance.
Out-of-pocket (OPM)	Defined as an individual's perception of the extent of the costs associated with visits to a physician, and diagnostic and treatment costs of the tracer. The index consists of a series of items (eight for Brazil, and four for Argentina and Mexico) for which the lower codes indicate a very high valuation of costs, the average being adjusted by the number of items.
Regular source of care (RSC)	Defined as seeing one particular doctor – a trusted or preferred physician – for medical advice or treatment. This is a dummy variable, in which 1 indicates that there is a regular source of care and 0 indicates that there is none.
Perceived need (PNE)	An index was created based on: i. symptoms experienced for each tracer condition during the last 6 months (relative weight = 0.2); ii. presence or absence of complications (relative weight = 0.3); iii. limitations in terms of work and physical activity attributable to the tracer condition (relative weight = 0.5). The lower the score the greater the perceived need for care.
Utilization (NUM)	Number of visits made to a physician during the last 6 months for hypertension and diarrhea, and the total number of visits made during pregnancy for prenatal care.

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[7] The typology is based on Bloch et al. (1996) where "Absence of coverage" includes cases where there is no affiliation with any social or voluntary provisional regime and the individual depends on public-sector institutions that provide emergency care and physicians' visits. "Limited health coverage" corresponds to *obras sociales* sindicales and "Medium health coverage" to services provided by mutual-aid societies, mixed-management *obras sociales*, intermediate-quality 'prepaid medicine' systems and the Programa de Atención Médica Integrada (PAMI, comprehensive health care program) for retired persons and pensioners. "High health coverage" includes the prepaid services system and the so-called hierarchical *obra social* (see Chapter 2 for details).

Appendix 2. Path Diagrams

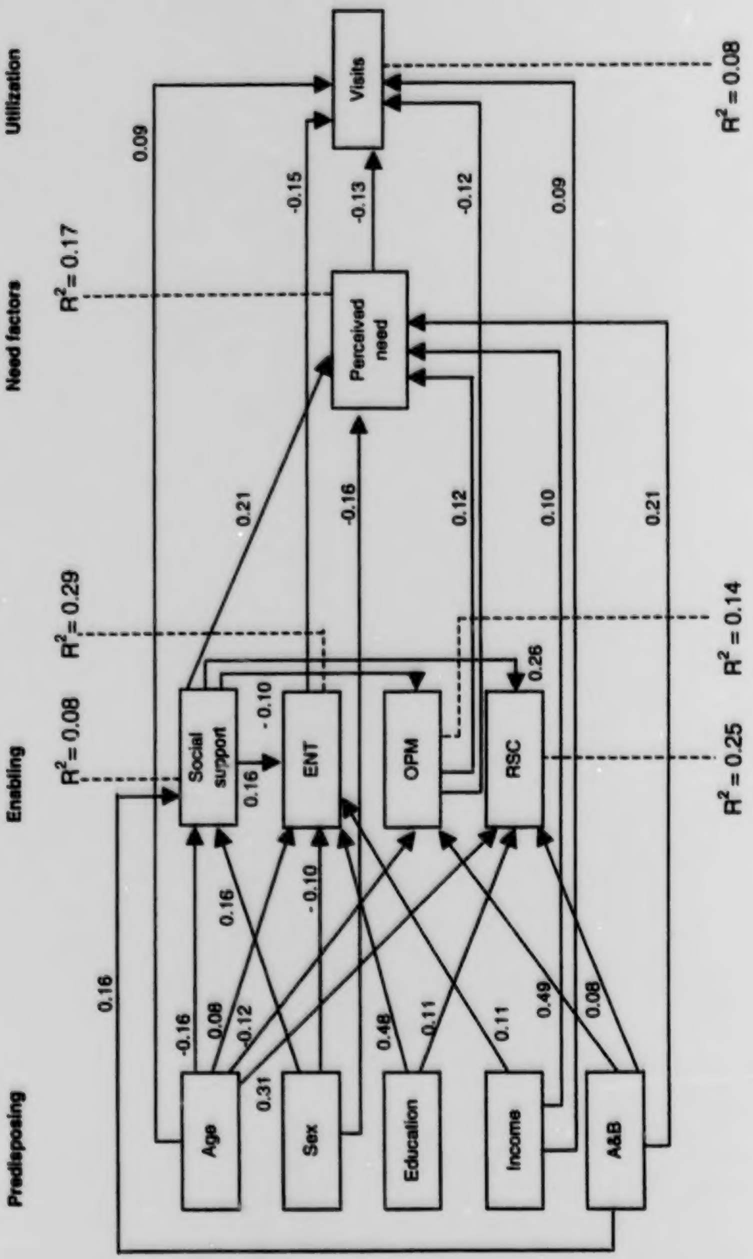
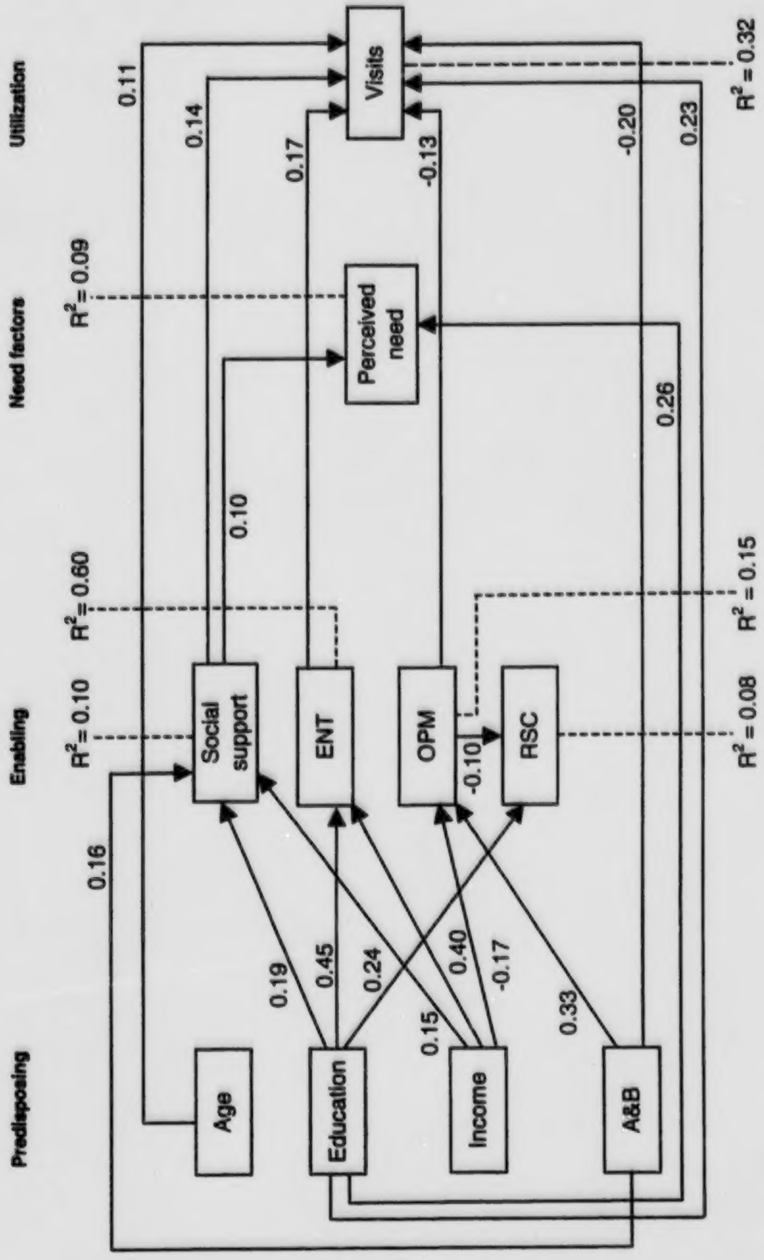

Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
$R^2 = 0.08$
$R^2 = 0.29$
$R^2 = 0.17$
$R^2 = 0.08$
$R^2 = 0.25$
$R^2 = 0.14$
0.16
-0.16
0.08
-0.12
0.31
0.16
-0.10
0.48
0.11
0.11
0.49
0.08
0.16
-0.10
0.26
0.21
-0.16
0.12
0.10
0.21
0.09
-0.15
-0.13
-0.12
0.09

Figure 2-a. Path diagram for hypertension — Argentina.


Predisposing
Enabling
Need factors
Utilization
Age
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
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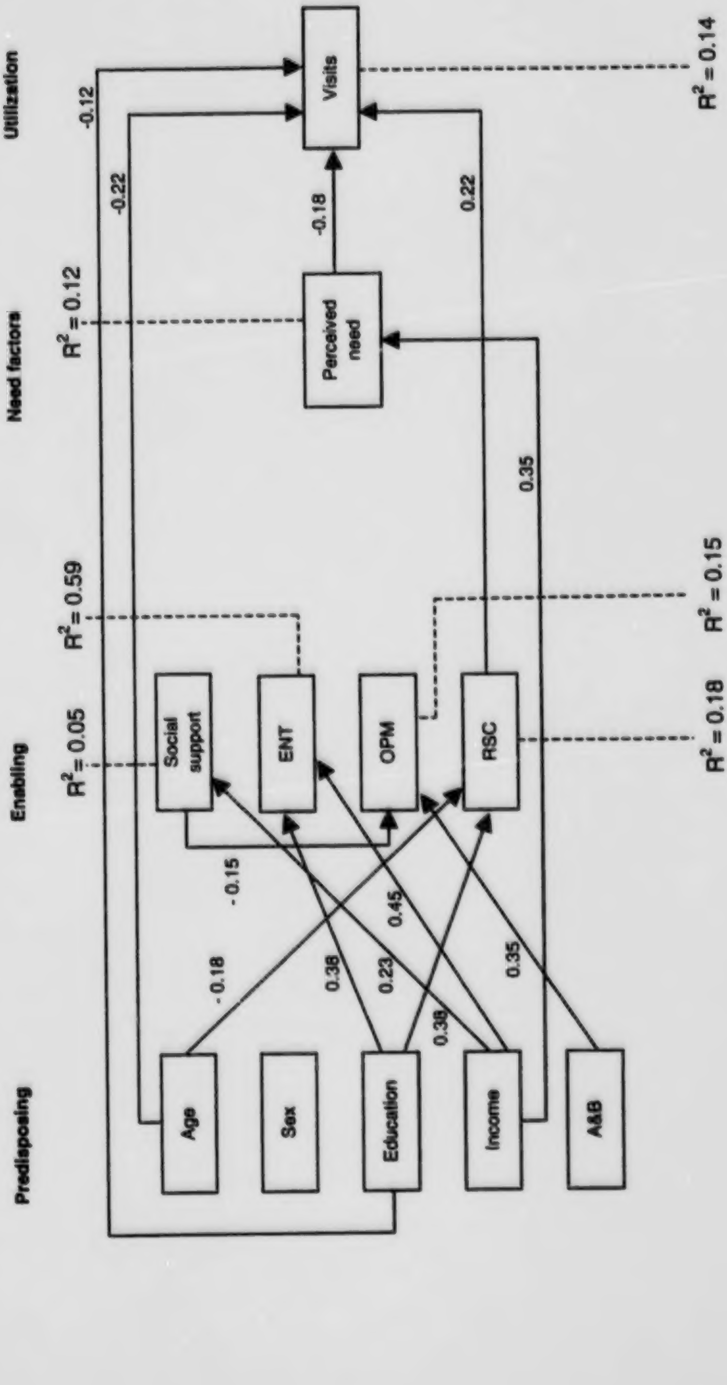
R² = 0.60
R² = 0.09
R² = 0.08
R² = 0.15
R² = 0.32
0.16
0.19
0.45
0.24
0.15
0.40
-0.17
0.33
-0.10
0.10
0.11
0.14
0.17
-0.13
-0.20
0.23
0.26

Figure 3-a. Path diagram for prenatal care – Argentina.


Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
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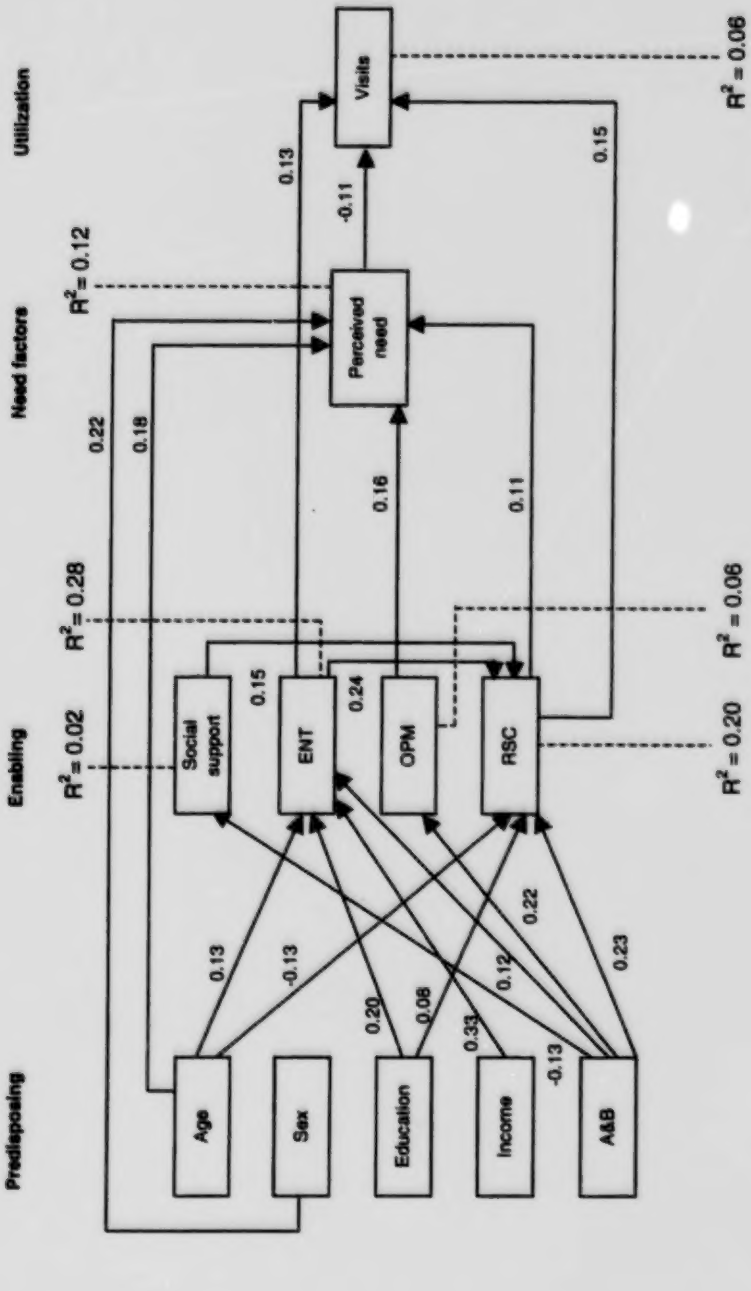
R² = 0.59
R² = 0.12
R² = 0.18
R² = 0.15
R² = 0.14
- 0.18
0.38
0.23
0.38
- 0.15
0.45
0.35
0.35
-0.12
-0.22
-0.18
0.22

Figure 4-a. Path diagram for diarrhea — Argentina.


Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
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-0.13
0.22
0.23
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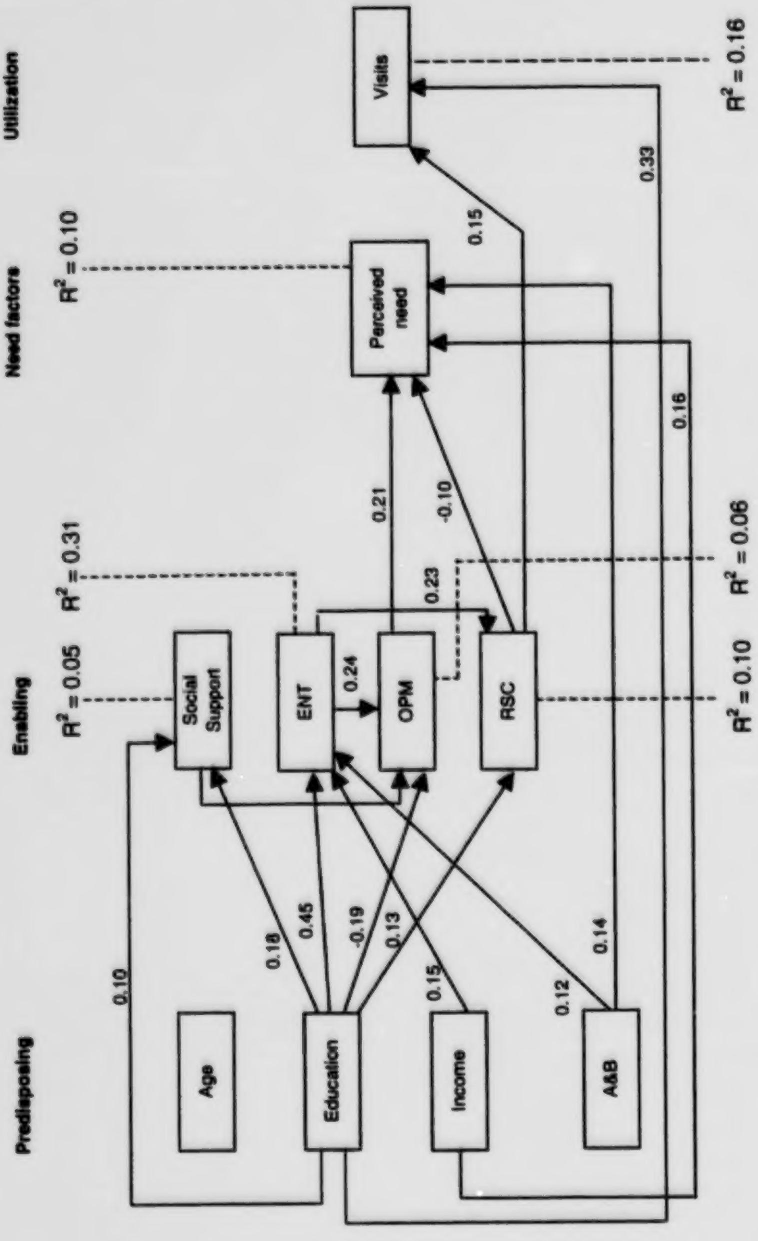
0.22
0.18
0.16
0.11
0.13
-0.11
0.15

Figure 2-b. Path diagram for hypertension — Brazil.


Predisposing
Enabling
Need factors
Utilization
Age
Education
Income
A&B
Social Support
ENT
OPM
RSC
Perceived need
Visits
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$R^2 = 0.06$
$R^2 = 0.16$
0.10
0.18
0.45
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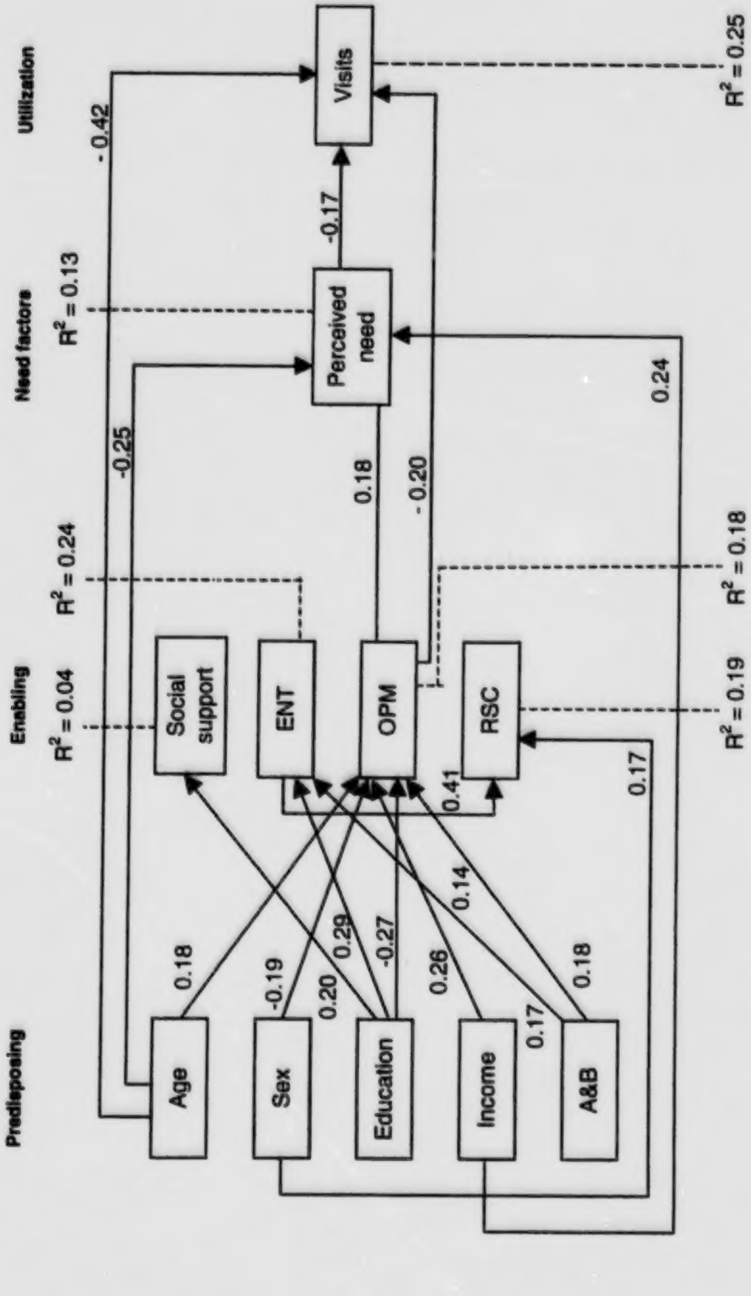
0.13
0.15
0.12
0.14
0.24
0.23
0.21
-0.10
0.15
0.16
0.33

Figure 3-b. Path diagram for prenatal care — Brazil.


Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
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R² = 0.24
R² = 0.13
R² = 0.25
R² = 0.19
R² = 0.18
0.18
-0.19
0.20
0.29
-0.27
0.26
0.14
0.17
0.18
0.41
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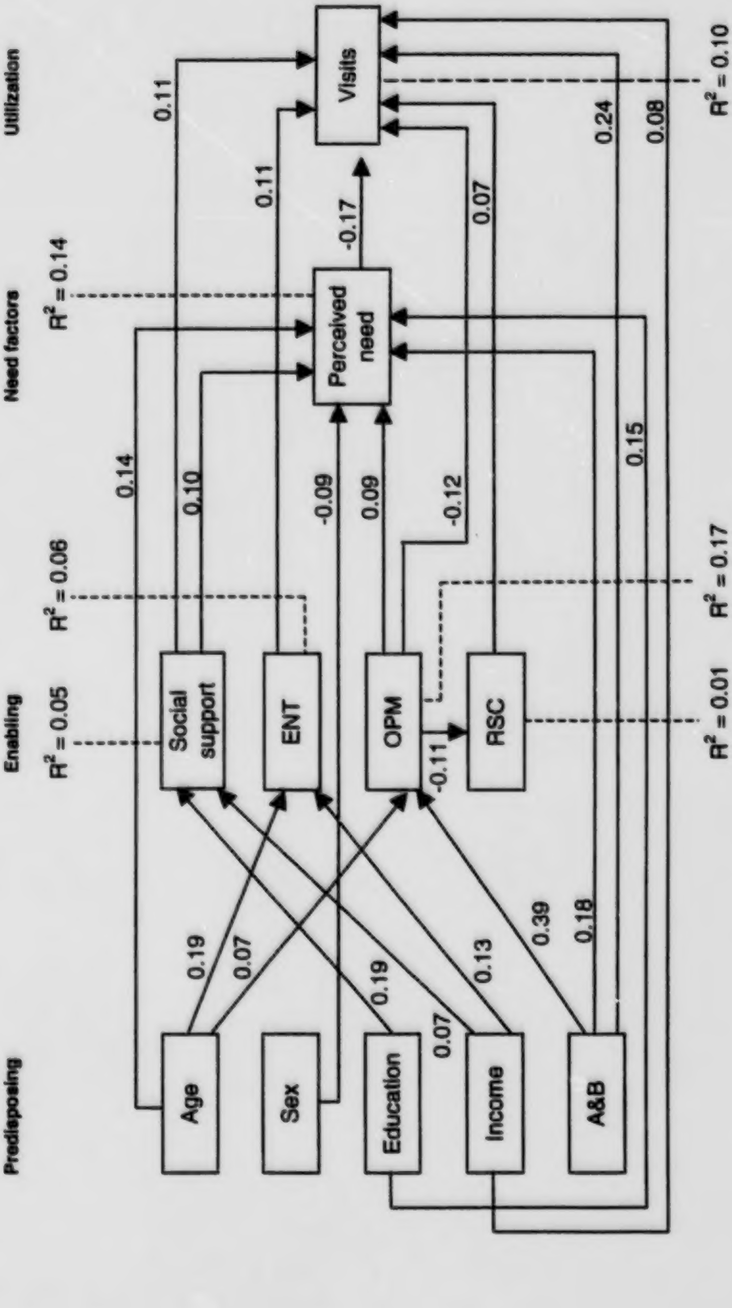
0.24
-0.25
-0.42
0.18
-0.20
-0.17

Figure 4-b. Path diagram for diarrhea — Brazil.


Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
Income
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
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0.19
0.07
0.19
0.07
0.13
0.39
0.18
-0.11
0.14
0.10
-0.09
0.09
-0.12
0.15
0.11
0.11
-0.17
0.07
0.24
0.08

Figure 2-c. Path diagram for hypertension – Mexico.

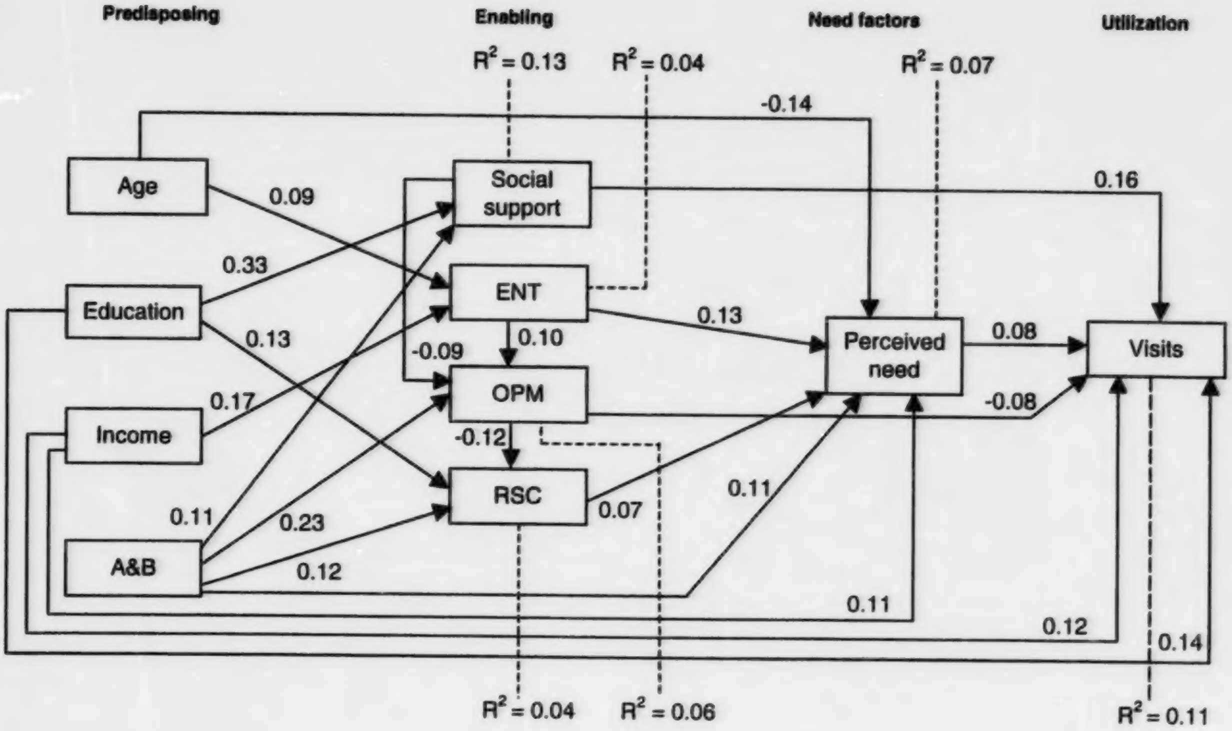
Predisposing
Enabling
Need factors
Utilization
R² = 0.13
R² = 0.04
R² = 0.07
-0.14
Age
Social support
0.09
0.16
0.33
ENT
Education
0.13
0.10
0.13
Perceived need
0.08
Visits
-0.09
OPM
0.13
0.17
Income
-0.08
-0.12
RSC
0.11
0.11
0.23
0.07
A&B
0.12
0.11
0.12
0.14
R² = 0.04
R² = 0.06
R² = 0.11

Figure 3-c. Path diagram for prenatal care — Mexico.

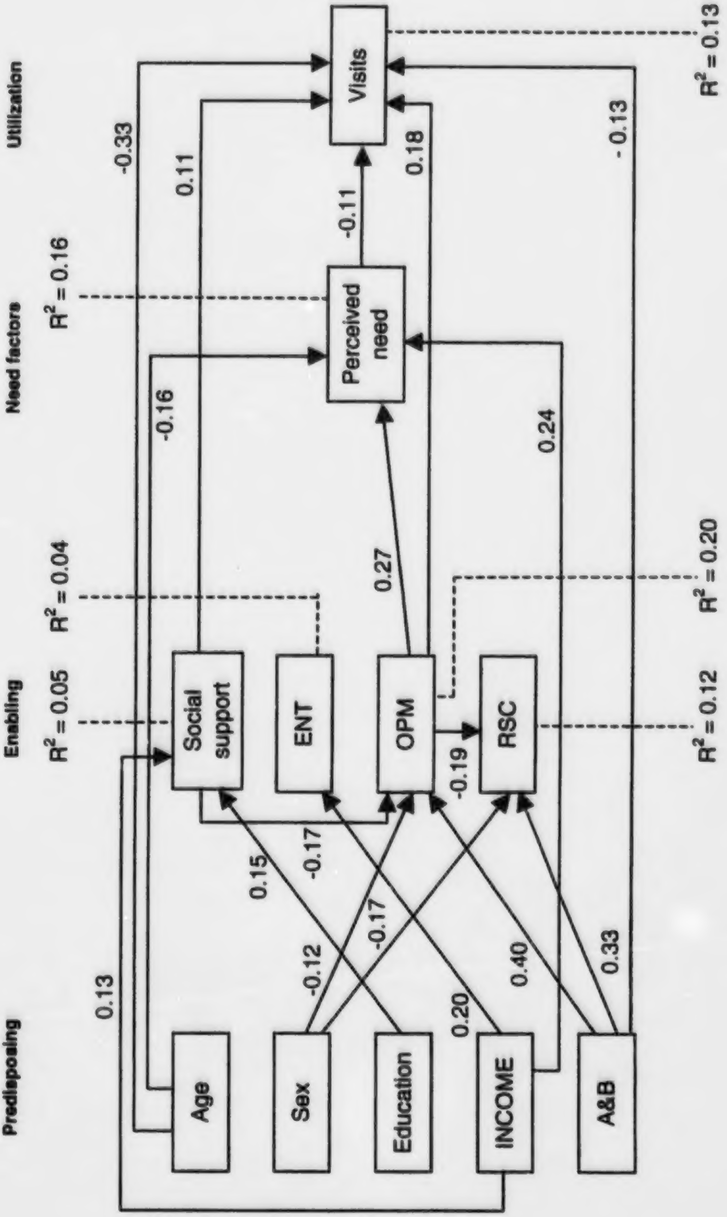
Predisposing
Enabling
Need factors
Utilization
Age
Sex
Education
INCOME
A&B
Social support
ENT
OPM
RSC
Perceived need
Visits
R² = 0.05
R² = 0.04
R² = 0.16
R² = 0.12
R² = 0.20
R² = 0.13
0.13
-0.12
0.20
0.40
0.33
0.15
-0.17
-0.17
-0.19
0.27
-0.16
0.24
-0.33
0.11
-0.11
0.18
- 0.13

Figure 4-c. Path diagram for diarrhea — Mexico.

SECTION IV.

CONCLUSIONS

Chapter 9.
Reshaping Health Care Systems in Latin America: Toward Fairness?

Sonia Fleury

Major Economic and Social Tendencies

The social policies that have developed in most Latin American countries are rooted in a similar development model. They are responsible for some of the most significant features of the relationship between state and society, as well as for incorporating a particular power structure into an institutionalized system. This pattern of structured social interactions is manifested in the following characteristics of the health sector:

- stratification and/or exclusion of certain population groups;
- fragmentation of institutions;
- a narrow and fragile financial basis, relying mainly on contributions from salaries; and
- strong actors with vested interests represented in the political arena.

The demand for health care reform arose when it became apparent that this pattern was incompatible with expanding the coverage, increasing the efficiency, and improving the quality of health care services in a context of financial shortage. Moreover, the recent movement of Latin American societies toward more democratic and pluralistic political regimes strengthened the demand for reforming the state and its traditional links with different groups in society.

Nevertheless, the possibility of designing and implementing a reform proposal will depend on the previously existing characteristics of the social protection system — including the health care system and social security — in each country.

Within the common pattern of social protection one can find huge differences between the countries in the region. While some countries spend almost 18% of their gross national product (GNP) on social policies, others spend no more than 8%. Social security coverage also varies, ranging from 20% to 90% of the population, according to Mesa-Lago (1991).

When one considers who is included in the social protection system and how resources are allocated among different groups, the characteristics of stratification and exclusion immediately come to mind as the variables best able to explain different arrangements of social protection in Latin American countries. The original studies of Mesa-Lago identified stratification as the salient feature of social security in the region. While Mesa-Lago's typology was based on the original timing of the emergence of public policy in this field and its subsequent trajectory, Filgueira (1998) built another typology, based on the combination of stratification and exclusion.

In Filgueira's typology (Filgueira 1998), the Argentine social protection system in the 1970s was qualified as a sort of "stratified universalism" because although it covered almost everyone, it was highly stratified with regard to the conditions of access to and benefits derived from the health system. As in Chile and Uruguay at the time, Argentina presented a situation in which the demands of a very organized and homogeneous working class were progressively incorporated into social policy (Fleury 1997). The resulting system was highly stratified, deeply fragmented, and under the control of the unions. Nevertheless, it constituted an important mechanism for redistribution.

Filgueira (1998) qualifies the Brazilian and Mexican health systems as "dual regimen" because, in the 1970s, the social security and the health system covered a small portion of the working class, while maintaining the same characteristic of stratification among those included in the social protection system. Due to enormous heterogeneity in terms of economic and socio-political development in the two countries, social policies served to act as a redistributive mechanism for those covered by the social security, while excluding the majority of the population (Filgueira 1998).

Almost all the other countries of the region except Costa Rica fall into the third type, a sort of "exclusive regimen," because social policies are part of a highly elitist system.

Thus, the three countries in our comparative analysis — Argentina, Brazil and Mexico — fall into two different categories according to the patterns adopted to institutionalize social protection prior to the reforms of the last two decades. This difference in institutional starting point will affect the course of the reform.

In recent decades, the deep economic crisis and the structural adjustment measures introduced by Latin American governments have resulted in a common scenario in countries where reform agendas are being carried out. In spite of these similarities, one must emphasize the fact that the three countries in question — Argentina, Brazil and Mexico — varied in the way that they faced this critical period, as well as in the effects of adjustment policies on their economic recovery. This gives us a picture of the overall setting in which health system reforms are being carried out. We should also add data concerning the resources for health systems, to have a better idea of the possibility of and constraints to implementing health system reform.

One of the most important features of the recent economic crisis was inflation. An acute form of hyperinflation occurred in Argentina during 1989-90 and is now controlled due to the economic policies adopted in that country. Brazil also had high inflation that lasted more than 5 years and seems to have only come under control during the last 2 years. Mexican inflation never reached the same level as in the former two countries, but it is still increasing (Table 1).

The lesson learned in recent years in Latin America is that inflation control provides a government with very considerable political capital, as it justifies economic adjustment policies in spite of their painful effect on salaries and unemployment. Success in defeating inflation, especially in countries where it has reached very high levels, allows governments to carry out social reforms with more freedom. Even so, however, they have to face stakeholders and deal with strong lobbies that have veto power in the social decision-making process.

The economic situation in Argentina may be characterized as stable and moving toward recovery. Although the economic reforms have accelerated economic growth, they have slowed the pace of job creation such that 17% of the labour force were unemployed in 1996 (IDB 1997). This situation is threatening the government's credibility and compromising conditions that were initially favourable to health reform.

Brazil is in a different position. Inflation has only recently been brought under control and recovery is still slight. The lower level of unemployment gives some credibility to the reform process, although increased unemployment is

Table 1. Average annual growth of consumer prices (%).

	Argentina	Brazil	Mexico
1986	85.7	125.0	86.2
1987	123.1	233.3	131.8
1988	348.3	690.0	114.2
1989	3 086.9	1 289.0	20.0
1990	2 313.7	2 923.7	26.6
1991	171.7	440.9	22.7
1992	24.9	1 008.7	15.5
1993	10.6	2 148.5	9.7
1994	4.2	2 668.6	6.9
1995	3.4	84.4	35.0
1996 [a]	0.2	15.0	34.4

Source: IDB (1997).

[a] Approximate.

expected as a consequence of the economic measures adopted to combat inflation. Persistent poverty has brought instability to the social and political scene. More than 40% of the population lives in a situation of moderate poverty — 46.3% in 1990 and 43.5% in 1995 — and more than 20% in a situation of extreme poverty — 24.5% in 1990 and 22.9% in 1995 (IDB 1997).

Between 1990 and 1995, Mexico saw an increase in the percentages of both moderate poverty and extreme poverty. Moderate poverty was 19.9% in 1990 and 22.3% in 1995, while extreme poverty was 11.3% in 1990 and 11.8% in 1995. The country's present economic situation does not favour a launch of social reforms that could negatively affect the interests of important groups in the political arena. On the contrary, social reforms would be driven by the need to rebuild a coalition supportive of the government.

The demographic and social data show other dissimilarities between the three countries. One important trend in the social field is population growth. The population growth rate is steadily declining in Argentina, recently underwent a sharp reduction in Brazil, and is slowing down smoothly in Mexico. Between 1970-80 and 1990-96, average annual growth rates fell from 1.7% to 1.2% in Argentina, from 2.4% to 1.6% in Brazil, and from 2.9% to 2.1% in Mexico (IDB 1997).

Of the three countries, Argentina is in the most favourable situation for tackling social problems, not only in terms of its population growth rate but also with respect to its lower reducible gap in mortality (Table 2).

Table 2. Reducible gaps in mortality.

Country	Total reduction (%)[a]
Argentina	18.1
Brazil	57.1
Mexico	40.2

Source: PAHO (1994).

[a] Total percentage of reducible death for the population under 65, 1985-89.

From a historical perspective, Argentina's favourable situation has nonetheless vanished, because in this country the reducible gap in mortality narrowed up until 1975-79 and then started to widen, ultimately reaching and even exceeding the levels that prevailed in the 1960-65 (PAHO 1994).

Although Brazil is in a difficult position because of enduring inequities, the Mexican situation is the most unsatisfactory in terms of availability of resources for the health system (Table 3).

Table 3. Resources in the health care system, about 1991.

Country	Population per doctor	Population per nurse	Hospital beds per 1 000 population
Argentina	330	1 650	4.4
Brazil	670	6 700	3.5
Mexico	1 850	2 310	0.8

Source: UNDP (1994) and PAHO (1994).

The serious lack of nurses in Brazil could be explained by the predominance of hospital care over outpatient care in this model. An example of inequitable access to highly specialized services and hospital units in Brazil can be seen with respect to professional care during delivery, which compares unfavourably with the situation in the other two countries. In 1991, 95.4% of deliveries in Argentina and Mexico took place under professional care, while in Brazil only 70% did (PAHO 1994).

Even with fewer resources, Mexico achieved a better level of professional care during delivery than did Brazil, in fact, the same level as Argentina. The variation here could indicate the extent to which the prevalent health care model in each country gives more or less priority to prevention at the first level of the health care system.

Regarding social security coverage, important differences can be observed between the three countries. Although social security expenditure on health in Argentina rose during the period 1980-90, from 2.8% to 3.3% of gross domestic product (GDP), it declined in Brazil from 1.5% to 1.2% and in Mexico from 1.3% to 1.0% during the same period (PAHO 1994). These data, however, do not indicate actual access to health care services. Considering the deep economic recession in Argentina during this period, political pressure may provide a possible explanation for this increase.

Social security expenditure per capita on health in these countries varies greatly. In 1990, the health expenditure per capita on social security was US $167.8 in Argentina, US $26.4% in Brazil, and US $38.8 in Mexico. Health expenditure in Argentina is more than six times that in Brazil, suggesting that universal coverage in the latter may have been achieved at the expense of quality of service.

Other measures of health care use also differ in the three countries being compared. For example, around 1991, the number of consultations per person was 1.6 for Argentina, 3.0 for Brazil and 1.7 for Mexico, while the bed turnover was 22.7, 34.7, and 51.7, respectively. Dissimilarities in the use of health care services in the three countries are probably be better explained by the configuration of the health system than by the epidemiological profile.

In Mexico, the public sector and social security (including the military services) are responsible for more than 85% of the hospital beds, whereas in Argentina they account for about 57%. In Brazil, the public sector (including social security) owns fewer than 30% of the available hospital beds, most of them in units with few beds.

The three countries also have different epidemiological profiles, either in terms of the health condition of the population or its situation vis-à-vis the health care system. In 1994, the major causes of death in Argentina were cardiovascular diseases and malignant tumours — a typical profile for an aged population.

In 1995, the major causes of death in Brazil were cardiovascular diseases, symptoms and diseases of uncertain definition, and external causes. In this case, the epidemiological profile shows a country with some characteristics of a developed society, along with others indicative of poor health care coverage and the existence of violence in large cities.

In 1990, the major causes of death in Mexico were accidents, cardiovascular diseases, and respiratory diseases — a mixed profile, featuring the effects of violence, an ageing population, and poor child nutrition.

Comparing these countries' health expenditures and health outcomes shows a positive correlation between public expenditure and positive health indicators (Table 4). Not surprisingly, Argentina has the best outcomes, both in terms of access to health services and quality of life.

Table 4. Health expenditures and outcomes by country.

	Argentina	Brazil	Mexico
Total health expenditure, 1990			
Public as % of GDP	5.85	2.76	3.1
Private as % of GDP	3.7	3.64	2.36
Aid flow as % of GDP	0.01	0.02	0.03
Total as % of GDP	9.56	6.41	5.49
Public[a] plus aid as % of total	61.28	43.2	56.88
Private as % of total	38.72	56.8	43.12
Health outcomes, 1991-92			
Per-capita (international $)	418	296	335
1-year (immunization)	87	18	92
Infant mortality rate, 1992	24	58	36
Life expectancy, 1992	72.1	66.3	70.8
Access to health care (%)	92	72	77

Source: Various; IDB (1996). [a]Includes social security systems.

Brazil is the only one of the three countries in which private expenditure exceeds public expenditure on health. However, even though Brazil expends more resources on health than Mexico does, the outcome of the Brazilian system is worse than that of the Mexican system. In addition to the difference in the weight of the public sector in the two health care systems, there are certainly other variables affecting these results, such as economic performance and inequitable distribution of the benefits from economic growth.

The Health Reform Process

The political arena, proposals, and strategies

Argentina

In Argentina, the health care system has historically been divided into three relatively independent sectors: public, private, and social security. The decline in the public sector from the 1960s to the 1990s has been compensated for by growth in the social security sector and by the expansion of private services.

The social security health care system that was institutionalized in 1970 comprised, until recently, a considerable number of institutions. The *obras sociales*, acting as health insurance funds, grew under the control of the trade unions. These institutions supplied health care to their beneficiaries primarily by contracting services from the private sector, but also through their own health facilities. This organizational model generated a high degree of fragmentation and diversity within the health care system.

The inability of the state to regulate or coordinate the system gave rise to a situation where control was held by two groups of corporate organizations. The first group was composed of financing entities (*obras sociales*) and politically represented by the Confederación General del Trabajo (CGT, general labour confederation). The other group was composed of medical associations and organizations of private hospital owners. The first group controlled the demand for medical services while the second controlled the supply.

This background to the Argentine social security health care system accurately describes the political arena in which reform took place. On one side were the powerful corporate organizations, those representing the interests of the trade unions and their capacity to finance health care and those representing the entrepreneurs who provide health care. On the other side was a weak bureaucracy, unable to put into effect many of the legal instruments passed by the government and thereby reduce the trade unions' control over the system.

Some concurrent economic factors have altered the power structure in the health field, as profound changes in the labour market have eroded the trade unions' prominent position on the political scene. Moreover, additional actors have entered the political arena during the reform process, especially with the increasing importance of private health insurance companies.

With the breakdown of the corporate pact between the trade unions, the professional corporations, and the political parties that had ruled Argentine society for half a century, the government adopted the reform agenda proposed by international agencies, bringing to the health arena the important participation of international policymakers.

To summarize, the health care system in Argentina was highly fragmented — between the *obras sociales* and the Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) and between individual *obras sociales* — producing unequal conditions of access to and use of health care services. The decision-making process was concentrated in the hands of the corporate organizations, both on the supply and the demand sides. The deterioration of the public health services from the MSAS, along with the increasing perception on the part of users and professionals that the *obras sociales* were being mismanaged, created the preconditions for the reform process.

The health reform process in Argentina is, therefore, partly due to the loss of credibility by the political actors who controlled the sector for many decades — the trade unions, the professional corporations, and the political parties — and the introduction of new actors, such as the international bureaucracy and private health insurance companies.

Nevertheless, health reform cannot be understood in isolation from the entire market-oriented economic reform launched by the government during the last decade. In Argentina, health reform was inspired by the principles of efficiency and quality, to be achieved through competition in a market regulated by the government. The reform project was designed to create the necessary regulatory capacity in government agencies; to eliminate monopoly and oligopoly on both the demand side and the supply side; to encourage competition by providing services through both public and private organizations; and to reduce the role of the national government in subsidizing or providing services to those unable to acquire insurance.

The legal instruments that were issued to provide a judicial framework and political guidelines for the reform attempted to reduce the power of the main corporate organizations in the health sector, thereby destroying their monopoly or oligopoly by encouraging competition. The *obras sociales* had to compete for affiliations, as well as for contracts with private providers. The banning of collective agreements between *obras sociales* and providers' associations, and the deregulation that gave workers the right to chose their own *obra social*, as opposed to being part of a captive clientele, were the main instruments of the new policy.

Other important measures were taken to transfer public hospitals to provincial jurisdictions through administrative decentralization, and to encourage public hospitals to become self-managing. Self-management allows a hospital to participate in the competitive market, either by being funded on the basis of production, efficiency, and type of population served, or by charging those able to pay for services received.

These reform measures had to face powerful opposition from the CGT, who felt that allowing competition between individual *obras sociales* would open the door to competition between the *obras sociales* and the international health insurance institutions.

The other pillar of reform, liberalization of contracts, produced considerable impact, affecting both the supply and the demand for services. The corporations that had traditionally predominated in this sector quickly lost the supply oligopoly, and new competitive forms of contracting emerged. The course of reform generated a paradoxical situation, in which a deregulated supply system found its competitiveness favoured as a result of the fragmentation of the demand, each fragment controlling a different level of resources.

Brazil

In Brazil, the reform process was based on two different — and in some instances contradictory — pillars. These were the transition to democracy, which was accompanied by the obligation to incorporate the excluded population into the political and social system, and the necessity of making a financially and organizationally frail health system more efficient and effective.

In this context, the proposal for a public, universal, and democratic health care system emerged. This proposal strengthened the social movement and civil society organizations and has been partly adopted by the government health bureaucracy.

The transition to democracy in Brazil has been characterized as an agreement between the traditional elite and the emergent political forces, under pressure from revitalized social organizations and increasing general dissatisfaction. However, the traditional economic and political elite was able to control the process of incorporating the emerging forces politically and socially, without having to substantially change the power structure.

Over more than two decades after the dictatorship regime excluded workers from the management of the social security institutions and proceeded to unify and centralize them in the hands of a powerful bureaucracy, the inept rule of the military and civil bureaucracy was revealed in critical and recurrent crises in the health care and social security systems.

During the 1970s, the dichotomy in the health sector was institutionalized when an increasingly decadent Ministério da Saúde (MS, ministry of health) was given responsibility for the health care of the whole population, while the strong social security apparatus was legally responsible only for providing its own beneficiaries with health care.

The expansion of health care by the social security system during this period was accomplished by contracting out to private providers on a fee-for-service basis. This strategy generated an intricate network of relationships between the social security bureaucracy and private providers, with dishonest activities on both sides.

However, the increasing demand for equal access to health services, combined with the inability to control health care costs, was strong enough to necessitate administrative reform of the social security health care system, integrating it into the MS network.

A combination of factors culminated in the social security crisis of the 1980s. These included the regressive and fragile financial basis of the system; the proliferation of expensive medical treatment without a corresponding change in financing; a method of paying for private services that stimulated the demand for high-cost specialized procedures and fraudulent operations; the difficulty of maintaining financial control because of the disorganized structure of the system itself; the deterioration of service quality; and the economic crisis in the country.

The health movement that had appeared as part of the revitalization of civil society was able to gather many forces opposed to the regime and formulate a coherent proposal for health system reform before any other political actor. The health movement's strategy was to take the reform into the legislative and institutional spheres as part of the process of rebuilding a democratic apparatus for the health sector. As usual in Brazilian history, the principal political arena came to be the state bureaucracy. There, many different actors played a game of confrontation and coalition, trying to get hold of the decision-making process, as well as the financial, technical, and political resources.

The main actors in this process were clustered around the social security institutions, not only the opponents of reform — represented by the traditional corrupt bureaucracy, populist politicians, and private providers under contract to the social security health care system — but also those leading the reform process. The latter was a broad coalition that was conducted by health intellectuals and technicians, and included some political leaders, legislative representatives, professional organizations, and popular movements.

The successful unification of the public services that brought social security health care under the direction of the MS, was preceded by a piecemeal strategy of decentralization, recovery of the public service network, and the spread of instruments for planning and budgeting, that invigorated the pro-reform movement.

The health reform was based on the principle of universality, as health was considered an activity of public relevance and a right of the citizen. The state had to assure equal access to health services by all citizens, giving a single direction to the public system. The public health system — Sistema Unico de Saúde (SUS, unified health system) — was structured according to a hierarchical and decentralized institutional arrangement, with each level controlled by a council with equal participation from government and civil society organizations.

The instruments to implement the health reform were both legal and administrative. At the same time, there was a great concern about the constant effort necessary to rebuild the reform coalition alongside the process of health reform, and to consolidate achievements in the process of empowering citizens and local-level public managers.

The main obstacle to implementing the reform guidelines was the government authorities themselves. Closely linked to private providers or influenced by international agencies, they made deep cuts in health expenditure in the initial years of the construction of the SUS, and tried to introduce new strategies aimed at improving efficiency through increased competition, thereby favouring the private network. These obstacles were responsible for the deterioration of the public services, which put the success of the reform in jeopardy.

The impossibility of shifting away from the curative and highly specialized health care model led to the paradoxical situation in which the reformers were caught. The SUS became the natural path for expanding the curative model in a way that completely favoured its former opposition, the private hospital owners. They kept their power to negotiate fees and prices and, rather than being threatened by the new system, ended up being one of its principal beneficiaries.

Recently, some incentives to develop preventive care have been issued by the MS, involving a subsidy and per-capita payment to the municipalities. These measures has been perceived as a way of increasing decentralization because they give local authorities greater autonomy in managing finances. Moreover, they are supposed to break the perverse chain of payments for hospital care, which sustains the curative model and perpetuates the unequal distribution of sparse financial resources.

The reformers' concern with the public sector meant that they avoided dealing with the increasing presence of health insurance companies in the health care system. This strategic mistake was responsible for the present situation, in which health insurance companies increasingly participate in health care provision with no control by the health authorities. The government has only now passed legislation to regulate the health insurance sector.

Mexico

The health system in Mexico is highly segmented with different institutions covering each group of the population. Each institution has its own network, without effective mechanisms of coordination either on the demand or the supply side.

The population covered by social security was grouped into three different types of institutions. The uninsured population received health care in multiple institutions designed for the population in general, such as those pertaining to the Secretaría de Salubridad y Asistencia (SSA, department of health), the Sistema Nacional para el Desarrollo Integral de la Familia (DIF, national system for the integrated development of the family) and the Instituto Mexicano del Seguro Social — Solidaridad (IMSS — Solidaridad, Mexican institute for social security — solidarity). A tiny segment of the population used prepaid services obtained directly from private suppliers.

Many problems arose from this structure, among which were duplication and waste of resources, and the creation of monopolies for different segments of the population. Probably the most serious problem was the overlap in demand: a high proportion of those covered by the social security system used private sector services or those of the SSA. In addition, despite repeated efforts to encourage decentralization, the system still suffered from the inertia generated by many years of centralization. To summarize, the health care system presented problems of coverage, stratification by population group, and centralization, as well as serious problems of duplication of services, poor quality, and inefficiency.

The players in the political arena were the public sector and social security bureaucracies; the traditional politicians and government authorities; and the insured workers, who mobilized after perceiving any plan of reform as a threat to their acquired rights.

An attempt to integrate the system into a single, national health care system was formulated in the 1980s, when it became imperative for the government to rationalize the functioning of public institutions as a means of reducing public expenditure in a context of economic crisis.

The creation of the Sistema Nacional de Salud (SNS, national health system) in 1983 had as its objective to launch administrative and organizational reform by creating different institutional and functional sectors, decentralizing, modernizing, and coordinating, as well as opening the possibility for community participation. This change also gave the SSA, a public agency, the power to plan and even budget for all institutions, including the Instituto Mexicano del Seguro Social (IMSS, Mexican institute for social security).

The proposed reform was fundamentally a state project, based on the results of weak negotiation between government representatives, employers, and labour organizations. Both the development and the implementation of the reform proposals were carried out by the government, mainly, the SSA. However, the success of the proposals depended on the support of all institutions, but especially that of the most powerful institution in the sector, the IMSS. The IMSS resisted submitting to control by a weaker institution and tried to prevent the balance of power from going in favour of the SSA. The proposed coordination of the health system by the SSA was unsuccessful, as the reform terms apparently undermined the basis of the corporate pact. A coalition was formed under the leadership of the IMSS, supported by the organized labour movement, which vetoed the reform.

Reduced public spending due to the economic crisis, combined with a growing policy of extending health care coverage, resulted in a gradual deterioration in the public services. This, added to the existing high levels of centralization and fragmentation, reduced the effectiveness and efficiency of the public health care services.

However, the government adopted an innovative approach in the form of a focused strategy to provide target groups, mainly those without access to any health care, with public health care services. Interestingly, through this program the traditional division between the social security and the public services became blurred, since public assistance was provided by social security through IMSS-Solidaridad (IMSS-solidarity). But, it also represented an irrational overlap of function between the two main institutions, while the discretionary use of the resources resulted in their being applied for political ends.

To summarize, the first attempt to reform the health sector aimed to create an integrated and coordinated health care system as part of the government's project to rationalize the public service. As an administrative reform, it was developed by an inner circle of public officials and did not achieve the necessary social and political support required for its implementation.

The new wave of reform in Mexico occurred very recently and differed from the proposal developed in the early 1980s. The reform is currently the subject of public debate among different actors with different proposals. The government project attempts to extend coverage through decentralization of public services and provision at the local level of a basic package of health care services through the public network and the targeted social security program. Concerning the social security health services, the project introduced competition between public and private services by allowing users to chose their insurance plans from the market. The mechanism that allows competition between social security and private insurance is a quota reversion system for insured workers who choose private insurance. It enables them to use their contributions to remunerate private health care providers.

One important change in the new reform process concerned the position of the IMSS. Having blocked the first attempt at reform, the IMSS has now formulated its own proposal. This proposal not only addresses the problem of financing and bringing efficiency to its services, but also includes a strategy to incorporate workers from the informal market. The mechanism to expand coverage is a family insurance plan for those able to gather the necessary resources to contribute to a collective health insurance plan.

This last point might not only provide a solution to the financial crisis in the system, but also enhance the credibility of the IMSS, by demonstrating that it is no longer interested only in defending the privileges of the few.

The fact that employers could be mobilized to debate the proposal was evidence of a new context for the Mexican policymaking process. As the reform in Mexico was only recently approved, it is expected that many adjustments will take place, since the political arena is changing fast in this country and the reform process is never straightforward.

Comparative Analysis of the Health Care Reforms

There is a twofold movement propelling the reforms in the countries under study: a movement to displace the institutional and political context in the health care sector from the central to the local level, and from the public sphere to the private one. Although this phenomenon represents a common tendency guiding the process of reshaping the health sector, there are many different possible arrangements to be considered as the strategy of the reform.

A comparison between the political context of the reform movement in the three countries reveals that in Argentina, Brazil, and Mexico, reform started as part of a crisis of authority, against a background of profound economic change. An important feature of the reform was the loss of power by some previously dominant actors. The emergence of a new vision to reshape the relationship between the state and different groups of civil society may come either from organized civil society groups, as in Brazil, or from government authorities, as in Argentina and Mexico. The ability to implement that vision, however, depends on the capacity of each side to keep or enlarge its coalition, once many powerful interests start to be affected by the reform measures. Indeed, there is a difference between a reform project that comes from society and has to be incorporated by government through public policy, and a government project that needs to avoid the veto power of important groups in society and the bureaucracy and enlist the support of others.

Some actors have played a pivotal role in the process: the health bureaucracy, the social security institutions, private providers, international agencies, and civil society organizations. Although the relationships between them vary according to each national context, there is a common impetus provided by the macroeconomic scenario, in which the changing role of the nation-state, the liberalization of markets, and the encouragement of competition are the main factors reshaping economic and social institutions.

Besides the economic component, represented by reduced public expenditure, and the political component, represented by actors with the capacity to organize a strategy either to support or oppose the project, there is a further component at the base of the reform process. It is represented by the emergence of a new dynamic in the health care market favouring the more competitive private providers and insurance companies. The weight of the private sector, represented both by its presence as a health provider and its strength in the insurance market, is an important variable that could define the scope of public policy. This is especially so when public policy depends on private provision and/or the private insurance became a strong economic and political actor before the government had time to regulate its activities.

In comparing the three countries, it is obvious that the reform process has not been straightforward in any case, and has gone backward and forward according to the political and economic context. Analysis of the three reform processes reveals similarities and differences regarding some core issues that appear to provide useful guidelines for a comparative study of health reform. These include the timing of the reform, the design of decentralization, and the make-up of the reformed system.

The timing of the reform

In the three countries, health reform took place in a context marked by two main processes: the economic crisis, followed by structural adjustment policies, and the transition to a more democratic regime. Nonetheless, the timing of the health reform with respect to these two processes seems to be a crucial variable in determining the proposal, contents, instruments, and political actors in the health reform.

Although the transition to democracy and economic adjustment are not finished yet, it is possible to consider health care reform in the three countries, in relation to the vertex of these two processes, as follows:

Timing of the health care reform.

Countries	Transition to democracy	Economic crisis
Argentina	Subsequent	Concurrent
Brazil	Concurrent	Previous
Mexico	Concurrent	Subsequent

In Argentina, health reform was noted for its close links with the market-oriented reform of public administration and the coalition making up the important political force called the *Movimiento Justicialista* (justice movement). The loss of power of the trade unions in the political arena was reflected in their inability to veto the project to reorganize the *obras sociales*, orchestrated by the public bureaucracy with the support of the international agencies.

Therefore, the proposed health reform in Argentina was mainly oriented toward improving efficiency and transparency in managing the funds collected by the *obras sociales*, through the introduction of competitive mechanisms on the demand and supply sides.

In this situation, the success of the reform depends on the ability of the reform coalition to associate health reform as part of the economic and political restructuring, and to prevent the unions from regaining their former political role. Of course, the success of this strategy will depend on the extent to which economic recovery is achieved. On the other hand, it will also depend on the creation of the required administrative and technical capacities in a traditionally fragile state in order to regulate and control the new emergent actors.

The Brazilian case of health reform is unique in Latin America because the reform project was formulated as an answer to the political crisis in the authoritarian regime, and therefore preceded the economic crisis and structural adjustment policies. Due to the fact that the motivation for launching the reform was basically political and ideological, the proposal was formulated in terms of democratic values, such as equality of rights and participation in the policy-making process. Similarly, the composition of the reform coalition was rooted in civil society organizations and, thereafter, in their occupation of strategic positions inside the bureaucracy.

The capacity of the reformers to deal with an adverse economic situation, with the consequent restriction of public financial resources, remains the principal challenge in this case. In order to stay the course they must adapt the strategy and instruments of the reform while resisting any attempts inspired by financial limitations "to reform the reform."

As the government is constrained by the economic crisis, the possibility of preserving the original direction of the reform depends upon the capacity of the leaders to bring together the same political coalition and increase its power as a by-product of the reform. In addition, the success of the reform depends on the development of a recognizably better health care system in a very unfavourable economic situation. In this sense, the reformers must add improving the efficiency and quality of health care services to the political agenda, even if it puts them in a position of permanent conflict with the health professionals.

The first attempt to reform the health system in Mexico was not inspired by a political crisis. Authority at that time resided in a political elite in the single party that had been in power since the Revolution. The absence of a political and ideological crisis gave an administrative emphasis to Mexico's first reform effort.

The consequences of the adjustment to the economic crisis, the rise of insurgent guerrilla movements, and the emergence of a legal opposition coalition, have reversed the Mexican political situation. In this new setting, another attempt to reform the health sector has emerged, this time more rooted in political and economic interests.

The success of this reform project in Mexico will depend primarily on the government's ability to enlist the support of the Instituto Mexicano del seguro social (IMSS, Mexican institute for social security), because the feasibility of public policy is still determined more by the weight of institutional power than by organized civil society. Other important actors in this arena are the insured workers, who will fight to retain their differentiated status in terms of benefits. However, as soon as they perceive that the reform is not a threat to their situation, they will support it, making the reform into an instrument to regain the confidence of the middle class and best paid workers by the traditional political party. As society becomes better organized, the role played by the political parties in this arena will also increase, as a veto power, a negotiator, and a designer of alternatives to the governmental reform.

The decentralization design

All three countries have a federal political system overwhelmed by a highly centralized tradition. Both the transition to democracy and the definition of a new role and structure for the state within a new economic context have provided the impetus for decentralization. Nonetheless, the balance between these two movements and the nuances of the relationship between the central and local levels of government will result in different designs of the decentralization process, with respect to their financial, administrative, and political features.

Decentralization varies according to what functions are transferred (financing, regulation, provision, insurance); to which level of government they are transferred (regional, municipal, or both); whether they are transferred from the public administration to another institution, such as an autonomous agency or the private market; and the degree of empowerment that they confer on both local government and local society, in terms of decision-making in the areas of financing, management, and policy.

Considering public health care provision, the design of decentralization might be comprehensive, making all services and resources available at the local level; might be fractional, embracing only a certain kind of institution or level of health care; or restricted, espousing only one or a few programs. An important variable in defining the scope of the process is the role of social security in the health care system, since the structure of the social security sector is notorious for its centralization and ability to resist changes aimed at decentralization.

In the case of Argentina, the core of decentralization was the transfer of responsibility for social policy — public education and health care — to the provincial level, as a way of reducing fiscal pressure on the central government. As far as the reform of the *obras sociales* is concerned, as hypothesized above, there has been no change in their centralized structure and the reform is moving the social security system even further away from the public health system. Therefore, this situation can be described as a fractional decentralization of health care policy, since the decentralized public sector covers less than half of the population and represents only 21.76 % of health care expenditure (PAHO 1994).

Another important characteristic of the decentralization process in Argentina is the lack of an overall design of the resulting health care system, mainly explained by the fiscal motivation of the reform. The transfer of public health care institutions and financial resources to the provincial level gave the provinces autonomy in managing such resources, but was not followed by any national guidelines on how to reshape the provincial health care system. As the

Ministerio de Salud y Acción Social de la Nación (MSAS, ministry of health and social action) relinquished its role as a health care provider, it gave up exercising a steering role with respect to the reorganization of the provincial systems. This resulted in a different process being adopted in each the 23 provinces. A few of them continued decentralization to the municipal level, but most kept the system centralized at the provincial level.

The role of the MSAS is limited to its traditional functions of health promotion, technical assistance, and information. It has assigned the functions of regulating, monitoring, and auditing health care delivery to an agency, the Superintendencia Nacional de Servicios de Salud (national health services authority). This agency has the necessary administrative, economic, and financial autonomy to define quality standards and the basic health care package, as well as monitor cost-recovery in self-managing public hospitals and the process of selecting insurance plans by *obras sociales*.

The provinces receive general financial resources from the Fiscal Pact[8] and have autonomy to assign them to the public sectors. In 1995, public expenditure on health as a percentage of gross domestic product (GDP) was distributed among the various levels of government as follows: 0.21% at the central level, 1.18% at the regional level, and 0.27% at the local level (Cominetti 1997).

Decentralization to the provincial level can compromise equality between provinces inasmuch as the central government has abandoned its role as equalizer of regional disparities. The fractional character of health care decentralization is evident in the combination of mechanisms used to transfer the provision of health care to the sub-national level, while keeping the insurance policy centralized in social security and delegating regulation to an autonomous agency. At the provincial level can also be found the self-managed hospitals. This complex organization jeopardizes the possibility of coordination and synergetic interaction.

It is essential to establish a coordinating mechanism to negotiate policies and distribution of resources, as well as define criteria for allocating resources in such a way as to avoid the political misuse of health assets. A federal health council is responsible for articulating the efforts of the MSAS and the provinces, for example, in the definition of a program for quality assurance.

Decentralization, combined with a participatory strategy to create a single-command public health system at each level of government, is unquestionably the most impressive feature of health care reform in Brazil. The emphasis in this case was to create the right conditions for the municipalities to take responsibility for the local public health system, including the functions of provision, management of human and financial resources, control of the mechanisms of contracting out, and monitoring the private providers' network.

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[8] The Fiscal Pact is the name of the instrument for budgeting in the public administration.

The problems associated with decentralization toward municipalities are twofold: insufficient technical capacity at the local level to manage public resources, resulting in its appropriation by the traditional elite, and the difficulty of coordinating a process that involves, in the Brazilian case, more than 5 500 municipalities.

The strategy to decentralize progressively, according to a common framework defined at the central level, established some requirements to be fulfilled by the municipalities in order to achieve a greater degree of autonomy. Those requirements were comprehensive enough to include administrative, financial, technical, and political aspects.

The predominance of political and ideological objectives was responsible for the creation of important mechanisms for sharing decision-making power between local government and civil society. Likewise, important channels of negotiation institutionalized the interactions between the three spheres of government. Moreover, some spontaneous forms of coordinating the demand and supply between neighbouring municipalities sprang up throughout the country.

The empowerment of local managers created a new group of important actors and the participatory mechanisms increased the capacity of local community organization, which affected not only the health sector but also the entire local power structure that had been dominated by the traditional elite.

The composition of the reform coalition has changed as a consequence of the decentralization process. In the beginning, intellectuals and central bureaucrats predominated, while municipal health officials (*secretários de saúde*) are now in the majority.

The remarkable aspect of decentralization in Brazil was its option to give autonomy to the municipalities, although as part of a unified and comprehensive system. It is organized in a hierarchical chain of municipal, regional, and federal health systems with the same functions and standards, and with institutionalized mechanisms of coordination and participation.

In Brazil, decentralization of the health care system was made possible as a consequence of the general decentralization of financial resources toward the municipalities that was part of the transition to democracy. In addition to empowering the local level, the health reform featured a common design with a progressive and flexible strategy, which explains its success relative to other social sector reforms.

Nevertheless, the comprehensive and unified character of decentralization in the Brazilian case can only be fully understood if one takes into account the merger of the social insurance health care services with the public health care services. As the contribution to the social security system never had a specific percentage designated for health care coverage, it was easier to create a public health care system in the context of the fiscal crisis in social insurance. Another element facilitating this result was the previous integration of the health care network belonging to the social security system.

The central government controls the distribution of financial resources, attributing to local levels different degrees of autonomy to manage them. Thus, there is a permanent tension between the Ministério da Saúde (MS, ministry of health) and the municipalities regarding the power to control resources and the responsibilities of each level. In 1992, the distribution of public health expenditure among the various levels of government as a percentage of gross domestic product (GDP), was as follows: 1.26% at the central level, 0.36% at the regional level, and 0.47% at the local level. Besides the concentration of the resources in the central level, the autonomy of the local level to assign them is limited by existing compromises based on the payment of salaries and providers.

Although differences between local and national managers over the control of financial resources still exist, the conflict has been channelled through the creation of inter-management commissions, which represents a profound change in Brazilian centralized federalism.

The first attempt to decentralize the public health care system in Mexico during the 1980s failed due to its inability to extend the experimental project beyond the initial selected states, i.e. those best equipped in health care capacity. At that time, the government took a gradual and partial strategy, transferring some functions to the states but not the autonomy to manage the budget.

The political situation in Mexico in the 1990s demands a new federative pact, with the distribution of political and administrative power toward the regions and factions. The financial crisis in the social security system and the deterioration of the public health care network gave rise to reforms seeking improvement in efficiency. The necessity of extending health care coverage to those without insurance was at the root of the new proposal to decentralize the health care system to the state level.

In 1998, progress was made when functions and resources of the public health care network were transferred to 14 out of the 31 states.

The Secretaria de Salubridad y Asistencia (SSA, department of health) is responsible for elaborating norms and standards for the public health sector.

Coordination between the central level and the states is expected to take place through a national health council. Nevertheless, as the states are free to adopt their own health system. They have only to follow the guidelines concerning the minimum health service package. Thus, it is expected that disparities between states will widen, as is the case in Argentina.

The outstanding characteristic of the Mexican decentralization of the public health system that is taking place in the SSA network is that it is intended to extend coverage to a target population through the delivery of a basic service package via different programs at the provincial level. Besides, a similar program is being carried out by the Instituto Mexicano del Seguro Social — Solidaridad (IMSS-Solidaridad, Mexican institute for social security — solidarity) under the authority of the public health system, although not completely integrated with it.

In this sense, it is the decentralization of a target program rather than the whole health system. In addition to extending coverage, decentralization is motivated by fiscal concerns, since it is expected that the states will be able to contribute new resources to meet the demands on the decentralized health care services.

In conclusion, the process of decentralization in each of the three countries was impelled by different motives — fiscal balance in Argentina, empowerment in Brazil, and target coverage and fiscal balance in Mexico — and took different forms in each. Argentina and Mexico opted for decentralization to the intermediate (provincial or state) level, while Brazil decentralized toward the local level. In the first two countries, decentralization was neither regulated nor controlled by the central level of government, giving rise to different results. Nevertheless, the basic package of health care services remains similar. In the case of Argentina, decentralization acquired a special meaning with the autonomy of public hospitals, making it possible to incorporate market logic into the public services.

As for the scope of decentralization, it involved the whole health care system in Brazil; it was limited to the public services network and excluded the social security network in Argentina and Mexico; and, in Mexico, it focused on a particular program — providing a target population with a basic package of services.

The Make-up of a Reformed Health Care System

With respect to the analytical dimensions of health care organization, financing, provision, and regulation, substantial changes have occurred in the region over the past two decades. These have been responsible for an ongoing movement toward reshaping the health care systems in the three countries under study.

Three models of health care can be identified in all of them: the compulsory insurance model, the public integrated model, and the voluntary insurance model. In the 1970s, the compulsory insurance model and the public integrated model predominated, with the voluntary prepaid insurance model playing a minor role. At that time, they were compartmentalized, with no interaction between them. Over the last 25 years, they underwent various changes.

The public integrated model has undergone changes in the relations of authority and the organization of services through the decentralization process. The trend is in the direction of reserving a steering role for the central level and relinquishing the function of provider to the local levels.

There is also a tendency to guarantee certain target populations a basic health care package. The question is, is the public sector's responsibility limited to this package and to these target segments of the population, or does it also include those who can afford a supplementary health care plan. Another possibility would be to have a comprehensive and universal health care system.

Another trend is toward the creation of quasi-markets inside the public network, especially in the case of the public self-managed hospitals. This mechanism is already operating in Argentina, but not in the other two countries.

The voluntary insurance model has grown spectacularly over the last few years, simultaneously with the deterioration in the quality of public and social security services. In all three countries, the upsurge of voluntary insurance and its subsequent expansion and integration with other sectors was not regulated by the public health authorities. Recently, some initiatives to regulate the voluntary insurance sector have been launched as demanded by consumers.

The most important changes are undoubtedly occurring in the contracted insurance model. This is the core of the reform process in the period under study. In one country, Brazil, the social security health care network has been incorporated with the public health sector, generating a unified public sector that combines the characteristics of the public integrated model with the modality of contracting public and private providers, typical of the contractual insurance model. In the other two countries, the contracted insurance model has its own peculiarities. Argentina has a typical contracted insurance model, with the trade unions managing the financial resources of a risk pool and contracting health service providers. In Mexico, besides the function of social insurance, the social security system has its own health care services network, and is considered an autonomous part of the public sector.

The tendency to introduce competition in order to increase efficiency in the health sector takes a different form in each situation. In Argentina, there are two levels of competition: one between providers of health care to the insured population and the other between the various *obras sociales*. In Mexico the competition is between the public sector and the private insurance companies.

The main changes in the relationship between consumers, providers, and payers in each country are described below.

Argentina

The reform process in Argentina has mainly affected the compulsory insurance model, through the adoption of a set of measures designed to introduce competition and stimulate efficient management of resources. These measures have included breaking the oligopoly of the providers and creating a competitive market on the demand side of the health care system. The requirement of providing a basic health care plan, the introduction of freedom-of-choice affiliation, and the compulsory merger of institutions whose resources are insufficient to form an adequate risk pool are expected to change the compulsory insurance sector. Other measures to be introduced include limiting services to a minimum package and the possibility of making a supplementary contribution. This measure would represent the definitive breakdown of the hegemony of *obras sociales* in the health care system, and could be followed by the introduction of competition between *obras sociales* and private insurance companies.

So far, the relationship between third-party payers and providers has been the reform's main focus. The freedom to contract between payers and providers has affected the services system a great deal in terms of money flows, methods of payment, management, organization, and forms of regulation. One of the most important departures from the traditional system has been the transfer of financial risk from the *obras sociales* to the provider's network or intermediary organizations.

The transfer of risk to intermediary organizations has led to a new situation, where an interest in controlling demand and costs is part of the rules of the market, and an expected product of better management.

It is likely that the changes mentioned in the contractual relationships between payers and providers of services will have, as a secondary consequence, a further stratification of the beneficiary population.

Because changes in the system were not followed by a redefinition and enlargement of the public regulation function, the emerging market mechanism for regulation was directed toward cost control. But, a public mechanism accountable for policies to reduce inequality and control service quality is still lacking.

In the 1980s, the main regulatory mode was professional self-regulation. With the reform, self-regulation was replaced by management incentives within the intermediary providers' organizations. Recently, new mechanisms for accrediting and monitoring the education of health professionals and the quality of services are starting to be implemented.

Brazil

In the case of Brazil, the public system resulted from the unification of the public with the social security health care networks, thereby consolidating a new form of a public/private mix. The public sector is responsible for financing, regulating, and organizing the health care system in order to assure universal coverage. The public health care system operates as a third party, contracting for the services of private providers or using the same system of payment to transfer resources to its own services.

The reduction in federal resources during the end of the 1980s up to the middle of the 1990s was somewhat compensated for by the increasing, though still very low, participation of the states and municipalities in financing the health budget. This change has been accompanied by increased differentiation between municipalities in the importance that they assign to the health services, as well as in the quality of health services.

Recently, a national contribution was created to cope with the financial needs of the health sector. Although provisional, it indicates a tendency to look for new mechanisms of financing the health sector. This new contribution is claimed to be a way of coping with the halt of funds from the social security system and the instability of resources from the national budget.

Decentralization did not change the fact that the state remains the main payer for health care provided in private institutions. It did, however, stimulate an increase in local investment in the creation or recovery of the public service network. An effort is being made to control costs and rationalize the use of services.

An important change concerns the mechanism of allocating financial resources to private and public providers. The fee-for-service mechanism used to pay private providers was considered uncontrollable, and has been replaced by a type of diagnostic-related group (DRG) procedure for transferring funds. The transfers to public providers follow the same tendency, in some cases replacing traditional budget mechanisms for DGR, plus some transference on a per-capita basis, in an effort to avoid the tendency toward the proliferation of curative and specialized medical care.

The flow of resources from the national to the state and municipal levels is based on the stage of financial management autonomy attained in each state and municipality, as measured against a standardized scale set by the federal government.

With respect to the relationship between payers and providers, the new inter-management commissions are now responsible for determining the amount of resources that states and municipalities will receive, and for determining their management situations. The decision-making process has become more transparent, and mechanisms for conflict resolution and negotiation have made it more rational, especially through the creation of a health council, where, at each level of government, providers and users are represented in the same proportion as the public authorities.

The introduction of some intermediate management bodies in Brazil, such as the inter-management commissions and health councils, has opened the door to innovative forms of regulation, although they are not yet fully deployed. Undoubtedly, a new form of regulation — neither bureaucratic nor corporate, nor laissez-faire — is emerging that can be used by the government and organized civil society to defend the public interest.

The reform dynamic inside the public sector, however, was not connected with the growing expansion of the voluntary insurance market, thereby, generating a dual system. Since the middle class fled to private insurance, the universal public system has been transformed into a specialized one, covering the poor. There are no cross-subsides between the two systems in order to generate solidarity among different groups of consumers. The public system, however, is fighting to avoid assuming the burden of risk selection practiced by private insurers.

Mexico

The Mexican case has been qualified as a health care system that makes a fundamental distinction between those who are entitled to social security health care and those who are not. Accordingly, it is possible to identify two health services models in Mexico during the 1970s — social security health care services and public services for the population in general. According to the typology used by the Organisation for Economic Co-operation and Development (OECD), which considers the critical feature to be the degree of integration between the functions of financing and provision, these two systems would qualify as integrated public systems. However, the two public systems — the one for those insured by social security and the other for the general population —

are not integrated with one another. They serve distinct population groups by means of distinct institutional networks of services. In other words, they are neither integrated in terms of coverage, or in terms of their financing and organizational structure.

Even though split into two parts, the public sector is still the most important health care provider in Mexico, considering the resources involved and the scope of coverage.

The emerging model in Mexico is characterized by the increasing importance of the voluntary contract model and by a proposed public contract model for the social security system. Although it has been a legal prescription for several decades, the public contract model has had a very limited effect and played practically no role in the general orientation of the national health system. Nevertheless, the reforms that were advanced since 1995, both within social security and in the public institutions have made feasible a substantial increase in the use of public contracts to access services.

The recent loss of domination by the Instituto Mexicano del Seguro Social (IMSS, Mexican institute of social security) and its increasing dependence on public funds might facilitate the transformation of the social security system into a public contract model. Under this proposal, financing would come from compulsory contributions to social security, but employers would have the option of allowing contributors to contract directly with private providers of health care. Through the quota-reversion mechanism, the public social security institute is obliged to return the compulsory quota to those who have private health insurance.

The combination of this financial mechanism with competition between public and private providers is aimed at achieving better standards of efficiency. As Mexico is a typical example of a corporate financing system with public provision, competition would present a way to introduce private practice, whether or not it was followed by actual privatization of public health units.

It is also expected that the highest income groups affiliated with the social security systems will probably transfer their funds to the private sector using the quota-reversion mechanism, while the lowest income groups will remain with the public institutions for the general population. This will tend to further stratify access to health care services on the basis of ability to pay. The stratification will thus be as follows: a basic package targeting the poorest groups; another mandatory package to be provided by social security institutions for the contributors; and an ever-growing number of private options for those who can afford to withdraw from the social security system.

Considering the organization of the public health care services, the proposal does not seem likely to transform it into a more rational and efficient system. The social security institutions have not merged into a single institution and continue to be independent from the public health institutions, although both of them are implementing programs targeting the poor. They answer to different authorities. One is decentralized while the other is not, with little integration at the central and local levels. Thus, these programs will probably follow the tradition of overlapping, irrational use of resources, and political bargaining and patronage in the health care delivery.

The reform in Mexico did not create an effective mechanism to cope with the segmentation of the clientele and institutions in either the social security health care network or in the public health care network for the population in general. The main instruments of the reform were financial mechanisms that create competition inside social security, by allowing the option of private health insurance, and the decentralization of the public health care network. The central health authority is supposed to regulate the basic package of services, for the social security and the public decentralized system, as well as the norms and standards of public health.

The reform is intended to limit the public health sector to the functions of regulation and financing, only providing health care to target population groups. Other population groups are supposed to obtain health insurance coverage, either public or private, in accordance with their ability to pay for it.

With the emergence of the public contract model and the encouragement of the voluntary prepaid contract model, options for meeting health needs are becoming more diversified. Nevertheless, a weakened state and the absence of any regulatory body or mechanism are not conducive to a balanced trade-off between the public and private sectors.

Comparing the three countries, it is possible to identify some common tendencies regarding the functions of financing, regulating, insuring, and organizing the health care system. Concerning the source of financing, there is no significant change, since it comes predominantly from general revenues and contributions based on salary. The frequent instability of public health expenditure, particularly fiscal expenditures from general revenues, has not been tackled. In some countries, limiting the public system to the poor and to a minimal package can be justified as a way of targeting needy populations and better applying limited public resources. But it also can be seen as a way of liberating the most stable resources — those from social security — and channelling them into the competitive private market, instead of generating a public pool to compensate for the instability of public revenues.

Instead of changing the conditions of funding the health sector, the reform basically consolidated the specialization of sources. Additionally, there was an attempt to create a new source of public resources in Brazil, while in Argentina it is increasing the amount of out-of-pocket resources as a result of the orientation of cost re-conversion in public services.

However, there has been a much more profound change in the way the resources are allocated. The reform of the payment mechanisms changed from subsidizing the supply of services to a new system whereby the money follows the patient. This system is compatible with the reform's aim to open the insurance and provision functions to competition. The demand subsidy is supposed to provide the necessary incentive to guarantee both the efficiency and the quality of services. However, in regions were the supply is scarce and there is no competition, this mechanism is worthless.

Even the reform proposal to create a public and universal health care system is facing the problem of allocating resources more efficiently, as a way of controlling costs and providing incentives to improve the quality and efficiency of some programs.

Problems of risk selection, the under-provision of services and under-insurance of certain groups, and revenue skimming are appearing as a consequence of deregulation and competition in the insurance and provision markets.

The public sector is mainly suffering from problems of under-financing, inflexibility (inability to introduce new managerial styles) and the resistance of the professional unions to changes in labour conditions. The inability of reform to improve the quality and efficiency of the public sector, associated with its specialization in the health care for the poorest population groups, might result in an increasing gap between this lagging sector and the more competitive ones.

Different alternatives to cope with this problem have emerged in the region. On the one hand, there is the introduction of autonomy and a quasi-market situation in more complex public services, distancing their operation from the public orientation. On the other hand, there has been an empowerment of local authorities and organized civil society as a way to build up consensus and generate new public standards. So far, this mechanism has only produced improvements in the quality of health care services when combined with significant changes in public administration.

Possible scenarios

As we observed, the main changes in the health care system in the three countries during the last 20 years are occurring as a consequence of the expansion of the voluntary contract model and the changes in the social security contract model. Concerning the public model, there is a common tendency toward decentralization, but it varies greatly according to the role and interactions of the public model vis-à-vis the voluntary contract and the social security models.

The former relative autonomy of the three models, each one with its own funds, authorities, network of services, and clientele, has been replaced by new forms of interchange between them. Although theoretical models of reform postulate a specialization of functions, in the case of a pluralistic system, or a compulsory integration under the public command, in the case of a unified system, the reality is not quite that defined in the countries under study.

On the one hand, the proposed transformation of the health services structure, currently segmented by institution and clientele, into an articulated functional health system, has to overcome opposition from traditional and powerful entrenched interests, especially those associated with the social security system. Also, it has been difficult to create the necessary capability to move the public sector from a providing role to a steering role.

On the other hand, the proposed unified public sector has to cope with its dependency on private health care providers and the growth of a frequently unregulated private insurance market.

Three theoretical scenarios can be drawn as a consequence of the process of reshaping the health care system in the three countries under study: the competitive, the dual, and the specialized.

Under the **competitive scenario**, market competition becomes the prevalent modality of organizing the health care system, subordinating or even replacing the debilitated public integrated and compulsory models.

The most important feature of the competitive scenario is provision, since beneficiaries can opt for any service they want, while the other functions such as financing and regulation are not significantly affected. Regulation tends to be weak due to the subordination of the public sector to a previously strengthened private market. As the sources of finance — public, corporate, and private — are preserved, but not integrated, consumer choice is basically defined by financing capacity and source.

There is a tendency in this scenario to replace the public provision role with a public insurance role. Due to the limited ability of the public sector to compete in terms of provision, it may specialize in insuring the poor population.

The change from the public assistance to the public insurance role is supposed to be preceded by the autonomy of the public hospitals.

Under the competitive scenario, decentralization will not occur in or affect the provider market, but the local health authority could be transformed into a local public insurance.

The **dual scenario** occurs when both the voluntary and the public system — compulsory and contracted — are strong enough to maintain their own form in parallel. Although in the voluntary model, access to health care depends on the capacity to pay for it, the parallel existence of a vigorous public system guarantees the principle of universal coverage and integrated health care.

The most important feature in this case is the transformation in the organization of the public sector, with the integration and decentralization of the public network. Inability to innovate in terms of financing, management, and regulation may jeopardize the existence of the universal public sector.

The possibility of maintaining this duality — a voluntary and a public model — depends on the ability of the public model to regulate the voluntary model, so that the public system does not have to assume the whole burden of responsibility for high-risk groups. Another condition is related to the possibility of changing the structure of the public supply — decentralizing and expanding it — and improving the quality of the public health care services. Both depend on increasing the financial and managerial capacity within the public sector.

Under this scenario, the decentralization of the public sector is crucial to transforming the structure of the public network, as well as the power structure in the health sector. It is a necessary prerequisite to guaranteeing the strength and democratization of the public sector. Empowering public health authorities and poor citizens to voice their demands and act as public advocates is essential now that the middle class and affluent consumers have left the public system.

The **specialized scenario** is one in which all providing institutions are defined and ranked according to the package of health care services they offer to each segment of the population. In this way, the voluntary and the public models do not exist in parallel nor in competition, but access and use are highly stratified according to the capacity of each group to pay.

Thus far, the reform processes that have taken place in Argentina and Mexico appear to identify with the competitive scenario, whereas the Brazilian reform is heading toward the dual scenario.

Nevertheless, one should consider these scenarios as general trends, because the reform processes are not straightforward. In this sense, the competitive scenario seems to be a probable path to a segmented scenario, due to the inability of the public sector to provide a competitive insurance for the poor. The most probable result is that public insurance will be so limited that the patient will not be able to afford to be treated in the best public or private health care facilities. Consequently, there will be segmentation of the clientele not only in terms of the source of financing, but also in terms of consumption of services.

The dual scenario is also very unstable because it depends on the two components maintaining the same strength and growth rate. As pointed out above, there are several ideological and political variables influencing the final result of this game. Nonetheless, the economic situation of the country, the fiscal deficit of the state, and the capacity to reform public management, will determine the possibility of keeping this scenario over time.

The important point is that all these scenarios imply the coexistence of different, non-integrated models. Moreover, because the voluntary model is steadily growing under all three scenarios, the user population will probably be re-stratified in terms of social rights and access to social services. In contrast to the traditional model of social protection in Latin America, where benefits depended on the political capacity of each segment of workers to negotiate with the government, the new stratification process will now be based on the purchasing power of each population group. Given the strong positive correlation between level of salary and position in the formal market, it is likely that this stratification will confine the poor to minimal health care consumption, in terms of procedures and quality of services.

Lessons from the experience

An analysis of the reform process in Argentina, Brazil, and Mexico reveals similarities and differences. It also makes it possible to extract some important lessons to orient decision-makers in analogous situations. Such lessons have been grouped in three main sets: the focus of the reform, the managerial issue, and health care utilization.

The focus of the reform

The health reforms under study have focused mainly on the internal relationships between the components of the health care system, such as payers, providers, regulatory agencies, and users. Since the reforms have resulted in few changes in the functions of financing and regulation, the most significant effects were felt in the areas of provision and organization of health care services.

However, a reform process affects three different dimensions of the health care sector and its relationship with the other societal structures. First, the reform changes the relationship between state and society, either by replacing political logic of action with market principles or by creating new forms of social control and participation. The reform also alters the balance of power between the different levels of governmental organization.

In this sense, the reform necessarily implies a problem of governance. Replacing old actors with new ones and stabilizing coalitions to support the changing process means altering the previous equilibrium in terms of political and material powers.

The process of reform was favoured by the appalling public image acquired by the public health care services over the last few decades and by the loss of prestige of the main actors associated with it — the central bureaucracy, the trade unions, and the professionals. It was also seen as a necessary change in the relationship between the state and society. This favourable common starting point is not enough to guarantee the continuity of the process, however, since it starts to change the balance of power between winners and losers.

Unless reformers are able to take into account the governance of the process and reorient their strategies accordingly, the technical aspects of the reform will be compromised, either as a result of inability to implement the changes or to foresee the possible results of the reform in terms of the balance of power.

The second dimension of reform is, of course, institutional. Consideration of the main relationships and functions linking the components of the system is fundamental. A system as complex as the health care system requires a high level of coordination and integration between its multiple actors, structures, and bodies. Coordination may determine the results in terms of efficiency, as well as competitiveness.

Nevertheless, the health care system must be seen in a wider sense, taking into consideration not only the health care services, but also its main inputs. The current processes have paid scant attention to crucial aspects such as human resources, equipment and medicines, and the development of science and technology.

With respect to human resources, there have been some initiatives to control the quality of training, but no consistent policy to enlist their support for the reform proposal. This oversight may be a consequence of the naive assumption that the desired goals are a natural by-product of competition in the health care market. However, international experience has demonstrated that health professionals are the main losers within a market-oriented health system.

Consequently, they tend to transfer their stress and dissatisfaction to the professional-patient relationship.

Another product of the change in working conditions under a market-oriented health system is the failure to tighten and consolidate relations between members of the health care team, as a result of the enlarging competition.

The emphasis on using competition to increase efficiency and reduce costs does not take into account that the cost of health care is mainly determined by the inputs consumed. The rise in prices originated principally in the sphere of production, not only in the sphere of provision, of services. Therefore, emphasis on controlling provision of services through competition can only reduce prices to a point and may generate problems of coordination.

The most important dimension to be considered in the health care system is undoubtedly the health care model. This means considering different orientations with respect to the health/illness continuum. These might include favouring a preventive over a curative orientation, promoting patients' responsibility for their lifestyles, adopting more or less aggressive treatment protocols, etc.

These are not disconnected aspects, but rather part of a totality that can be more or less explicit in the reform proposal. Moreover, in addition to the declared intentions, the way relationships between the parts of the system are organized, especially in terms of the flows of money and patients, can determine the final health care model.

Tragically, a reform oriented either by the principle of efficiency or the principle of equality may introduce a perverted logic of consumption characteristic of the most expensive and inadequate health care model.

The managerial issue

Although there is a strong managerial component in all the present health care reforms under study, it does not represent a homogenous trend.

Differences in the design of the system the in the three countries have already been pointed out. It may be observed that while the public-oriented reform presents a detailed and incremental proposal for rebuilding the whole system, the market-oriented reform lacks a comprehensive proposal for the health care system. In the latter, decentralization may or may not stop at the regional level, since the organization of the system is defined in different ways.

The proposal of a unique national system requires a common design, as well as the development of the managerial instruments to carry out the process, in terms of financing, regulation, and organization. In spite of the existence of a general design and also of an incremental strategy to implement it, the management of the system does not spontaneously generate better conditions for managing the institutions within it. In this sense, it is possible to affirm that a reform of the health care system may improve management at the systemic level, but not necessarily at the institutional level.

The opposite is also true. Improvement in the management conditions of the health care services does not necessarily lead to a better design and/or management of the health care system. In the former case, the problem appears as a well designed system that results in poor performance at the institutional level, threatening the credibility of the reform. In the latter, improved institutional performance is not capable of overcoming problems like overlap of resources or absence of coordination.

Based on this consideration, we would recommend that policymakers consider the twofold management approach, at the level of the system and at the level of the institution. Each level will require different managerial approaches and instruments in terms of benchmarks, controls, measures of performance, evaluation, information systems, resource allocation, etc. Both are essential to the reform process.

Another important aspect to consider in the design and management of the reform is whether or not the material basis necessary to implement the proposal exists. In spite of the fact that it is a basic consideration, it has not often been observed in the countries under study. The reform in Brazil proposed to create a unique, single national health care system even though the majority of the health care services were private. The result was a public/private mix, and great difficulty was experienced in subordinating the private services to a public orientation and regulation.

In the case of the Mexican reform, as well as the Argentine one, the predominance of public services and expenditure did not prevent the proposal from introducing the principle of market competition into the health care sector.

In the same way, the intent to reserve the steering role for the central level had to cope with the state's weakness or inability to orchestrate a non-unified system and to regulate a flourishing, deregulated market. Failure in the ways justice works and problems in assuring consumers' rights are part of the new situation.

The proposal to increase coverage has to deal with obstacles imposed by a highly concentrated network of services, in a period when public resources are not even sufficient to maintain the existing network, with few possibilities of increasing investment in order to guarantee broader access to the health care system.

The health care utilization

The utilization of health care services is a complex issue, since it includes several variables, including those classified as predisposing (social and demographic conditions), enabling (economic and political conditions), and need (perceived health conditions). Finally, the issue of utilization implies the possibility of accessing a health care service, sporadically or on regular basis, and the satisfaction of the users with the attention they received.

Comparing the results of the health services utilization survey, one can find interesting, although not conclusive, evidence of the determinants of access and utilization. In all three countries, for different tracer conditions (hypertension, pregnancy, delivery, and diarrhea), we always found some enabling variables that have a direct and significant influence on health services utilization.

Foremost among these were availability of health coverage, existence of a regular source of care, and out-of-pocket money. In any case, differences in the use of the services due to entitlement or to the impossibility to pay some amount for it. clearly indicate the degree of inequality in access to and use of the health care services. The influence of a regular source of care is also indicative of the degree of difficulty in accessing either a private service or the public health care system.

In all these situations, access and utilization of health services were primarily influenced by enabling variables, not by perceived need for care. The predisposing variable education, strongly differentiated according to the income level, also influenced the utilization of services. Similarly, attitudes and beliefs, in close relation with variations in income and education, affected the utilization of services.

Only in cases of chronic disease, such as hypertension, did perceived need have a direct influence on health services utilization. It would seem that patients with chronic conditions, in this case generally elderly people, recognize their symptoms and do not just learn to live with the disease, but also how to deal with the health care system so as to have their needs attended.

Nonetheless, the general tendency is to discriminate between patients according to entitlement and other limits to access and utilization. Although this situation cannot be attributed to the reform process, it is likely that the direction health reforms are taking may aggravate problems of access and utilization in these countries. The emphasis on co-payments, the stratification of beneficiaries by purchasing power, and the impossibility of guaranteeing effective conditions of access and utilization might exacerbate the present situation.

Concerning the utilization of services, health care reforms have to cope with the two main problems in Latin American social structure: exclusion and inequality. In a situation where resources are scarce and highly concentrated, each reform measure must be evaluated according to its effect on exclusion and inequality. Both issues must be considered independently, but simultaneously, since the same measure can affect each of them in opposite ways.

It is, of course, different in the developed countries, where reform proposals were primarily intended to address the increasing costs of health care services and resulted in increasing inequality. Only the United States, like Latin American countries, has also to cope with the problem of exclusion from the health care system.

Since the utilization of health care services is only one piece in a complex system of relationships, the reform process may be considered in terms of its effect on each of the dimensions of the health care system, namely, economic, political, social, organizational, financial, and personal.

So far, the main result of the reforms has been to extend coverage. Nonetheless, it may have different meanings depending on the strategy adopted. For example, the initiatives aimed at increasing coverage through target programs are addressing the problem of exclusion. However, if access is assured only to a limited basic package of services and or to isolated groups of the population, the guarantee of access does not cope with the problem of inequality. On the contrary, this strategy may result in the institutionalization of differentiated use of health care services.

In the same way, "universal" systems that do not eliminate barriers to accessing the system are not capable of tackling the issue of exclusion. In this case, a proposed universal system that cannot guarantee access and quality will probably end up being a poor health care system for the poor. The apparent contradiction between universal and target policies can only be overcome through a combination of selective programs to vulnerable groups able to promote their access to and insertion into a universal system.

It cannot be denied that health care systems are undergoing major changes with regard to their political constituency and organizational and financial modalities, and are heading toward a more pluralistic and competitive configuration. Undoubtedly, one can qualify Latin American health sector reforms as a kind of modernization of the traditional pattern of social protection rooted in populist political relationships. The traditional pattern of social protection, which featured the stratified inclusion of urban workers from the formal market and the exclusion of the poor in the informal market, was expressed in the separation of the main institutions of the sector: the ministry of health and the social security system.

The new design of the health care system is part of a process by which Latin American societies are assuming a new profile, with a more pluralistic and inclusive system of social protection.

Instead of denying membership to some groups, there is a movement to stratify the population according to the purchasing power of each group. The possible outcome will be that each individual will be entitled to rights and services to a greater or lesser degree, according to the population group to which that individual belongs.

While the former stratification was grounded in the collective action of the group, the new stratification will be determined by the individual's capacity to contribute — directly or through public subsides — to his or her own benefit plan. Unless the government finds a way to have the more affluent population groups subsidize the poorer population groups, the segmentation inherent in the former situation will tend to be reproduced.

Moreover, health policies are contributing to the segmentation of the population by pitting the middle class and the poor against one another, both culturally and politically. This breakdown in solidarity implies discrimination against the poor, as well as the likelihood that public health care services designated for the population without economic resources and a political voice will deteriorate.

So far, no mechanism has been designed to promote solidarity among the various stratums of users, as part of the reform in the three countries. If this situation continues, the reforms will succeed in modernizing the sector at the cost of moving the region even further away from the ideal of fairness.

Acronyms and Abbreviations

ALAMES	(Latin American association of social medicine)
AFORES	Asociaciones de Fondos para el Retiro (association of retirement funds)
AIDS	acquired immune deficiency syndrome
AIH	Autorização de Internação Hospitalar (hospital stay authorization)
AMB	Associação Médica Brasileira (Brazilian medical association)
ANSSAL	Administración Nacional del Seguro de Salud (national health insurance administration)
ANSSES	Administración Nacional de Sistema de Seguro de Salud (national administration of the health insurance system)
APs	Administradoras de Prestaciones (service managing organizations — equivalent to American managed care organizations)
BCP	basic care package
BEPS	budgetable expenditure for the public sector
CEPAL	Comisión Económica para América Latina (see also ECLAC)
CEPAL	Comissão Econômica para a América Latina (see also ECLAC)
CEPED	Centro de Estudios sobre Población, Empleo y Desarrollo (centre for studies on population, employment, and development)
CESS	Centro de Estudios Sanitarios y Sociales (CESS, social and health study centre [centre for health and social studies])
CGT	Confederación General del Trabajo (general labour confederation)
CFM	Conselho Federal de Medicina (federal council of medicine)
CNS	Conferência Nacional de Saúde (national health conference)
CONASEMS	Conselho Nacional de Secretários Municipais de Saúde (national council of municipal health secretariats)
CONASS	Conselho Nacional de Secretários Estaduais de Saúde (national council of state health secretariats)
COPLAMAR	Coordinación General del Plan Nacional de Zonas Deprimadas y Grupos Marginados (national program for depressed areas and marginal groups)
CTM	Central de Trabajadores de México (Mexican workers central organization)
CUSS	Contribución Unica de Seguridad Social (unified social security contribution)
DDF	Departamento del Distrito Federal (administration of the Federal District of Mexico City)
DIF	Sistema Nacional para el Desarrollo Integral de la Familia (national system for the integrated development of the family)
DGI	Dirección General Impositiva (general directorate of taxes)
DORL	disability, old age, retirement, and life insurance
DRGs	diagnostic related groups
EAP	economically active population
ECLAC	United Nations Economic Commission for Latin America and the Caribbean

FBH	Federação Brasileira de Hospitais (Brazilian federation of hospitals)
FROS	Fondo de Reconversión de Obras sociales (*obras sociales* reconversion fund)
FSR	Fondo Solidario de Redistribución (common redistribution fund)
FIOCRUZ	Fundação Oswaldo Cruz (Oswaldo Cruz foundation)
FUNSALUD	Fundación Mexicana para la Salud (Mexican foundation for health)
GDP	gross domestic product
GNP	gross national product
HMOs	health maintenance organizations
HSS	health services system
IAPs	Institutos de Aposentadorias e Pensões (retirement and pension institutes)
IBRD	International Bank for Reconstruction and Development
IDB	Inter-American Development Bank
IMPS	integrated microcomputer processing system
IMSS	Instituto Mexicano del Seguro Social (Mexican institute for social security)
COPLAMAR	Coordinación General del Plan Nacional de Zonas Deprimadas y Grupos Marginados (general coordination for the national program for depressed areas and marginal groups), now known as IMSS-Solidaridad
IMSS-Solidaridad	IMSS solidarity
INAMPS	Instituto Nacional de Assistência Médica da Previdência Social (national institute of medical care and social security)
INDEC	Instituto Nacional de Estadísticas y Censos (national institute of statistics and censuses
INOS	Instituto Nacional de Obras sociales (national institute of *Obras sociales*)
INPS	Instituto Nacional de Previdência Social (national institute of social security)
INSSJYP	Instituto Nacional de Seguridad Social para Jubilados y Pensionados (national social security institute for retirees and pensioners)
ISFAM	Instituto de Seguridad para las Fuerzas Armadas Mexicanas (social security institute for the Mexican armed forces)
ISSSTE	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (social security institute for civil servants)
LDO	Lei de Diretrizes Orçamentárias (budget directives law)
LOS	Lei Orgânica da Saúde (Organic Law of Health)
LOAS	Lei Orgânica da Assistência Social (social assistance organization law)
MS	Ministério da Saúde (ministry of health)
MSAS	Ministerio de Salud y Acción Social de la Nación (ministry of health and social action)
MTSS	Ministerio de Trabajo y Seguridad Social de la Nación (ministry of labour and social security)
NAFTA	North American Free Trade Agreement
NGOs	nongovernmental organizations

NOB	Norma Operacional Básica (basic operational norm)
OECD	Organisation for Economic Co-operation and Development
OFR	overall fertility rate
OMS	Organización Mundial de la Salud (see also WHO)
OPS	Organización Panamericana de la Salud (see also PAHO)
OSS	Orçamento da Seguridade Social (social welfare budget)
PAHO	Pan American Health Organization
PAMI	Programa de Atención Médica Integral (comprehensive health care program)
PARSOS	Programa de Apoyo a la Reforma del Sistema de Obras sociales (program in support of reform of the *Obras sociales* system)
PASSPA	Programa de Apoyo a los Servicios de Salud para la Población no Asegurada (support program for the health care services for the uninsured)
PEMEX	Mexican national oil company
PMO	Programa Médico Obligatorio (basic services package)
PNs	providers networks
PND	Plan Nacional de Desarrollo (national development plan)
PNUD	Programa das Nações Unidas para o Desenvolvimento (see also UNDP)
PRD	Partido de la Revolución Democrática (democratic revolution party)
PRI	Partido Revolucionario Institucional (institutional revolutionary party)
PRODEMAN	Programa Interuniversitário de Pesquisa de Demandas Sociais (inter-university program of surveys on social demands)
PROMIN	Programa Materno Infantil (maternal and child health program)
PRONASOL	Programa Nacional de Solidaridad (national solidarity program)
PRSS	Programa de Reforma del Sector Salud 1995–2000 (health care sector reform program, 1995–2000)
SAR	Sistema de Ahorro para el Retiro (savings for retirement system)
SAS	statistical analysis system
SDE	social development expenditure
SDN	Secretaría de la Defensa Nacional (department of national defense)
SECMAR	Secretaría de Marina (navy department)
SHCP	Secretaría de Hacienda y Crédito Público (department of inland revenue)
SINPAS	Sistema Nacional de Previdência e Assistência Social (national system of social security and social assistance)
SNS	Sistema Nacional de Salud (Mexican national health system)
SPSS	Statistical Package for Social Sciences
SS	Secretaría de Salud (department of health)
SSA	Secretaría de Salubridad y Asistencia (department of health)
SSS	Superintendencia de Seguros de Salud (superintendence of health insurance)

SUDS	Sistema Unificado e Descentralizado de Saúde (unified and decentralized health systems)
SUS	Sistema Único de Saúde (unified health system)
SUSS	Sistema Único de Seguridad Social (unified social security system)
STDs	sexually transmitted diseases
UAM-X	Universidad Autónoma Metropolitana –Xochimilco (autonomous university of Mexico — Xochimilco)
UCAs	Unidades de Cobertura Ambulatorial (ambulatory care units)
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
UTEs	Uniones Transitorias de Empresas (temporary associations of enterprises)
WHO	World Health Organization

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Reshaping Health Care in Latin America

A Comparative Analysis of Health Care Reform in Argentina, Brazil, and Mexico

Edited by Sonia Fleury, Susana Belmartino, and Enis Baris

In many countries of the world, including Canada, arguments are made for a private–public mix in the financing and provision of health services. Proponents claim that such a mix would improve both access and quality of health care. Opponents counter that it would create a two-tiered system, narrowing the range of options available to the lower socioeconomic segments of society and ultimately harming the equitable delivery of quality health care.

This book presents empirical evidence on this contentious and highly politicized issue. Uniquely, it integrates qualitative and quantitative analyses of health care reforms at various stages of implementation in three countries of Latin America. The book sheds light on important issues pertaining to accessibility and equity and, in its approach, sets precedents and provides guidelines for further comparative work on health care reform.

Reshaping Health Care in Latin America will appeal to academics, scholars, researchers, and students in health sciences, policy studies, Latin American studies, and international development. It will also be of interest to health practitioners, policymakers, and all citizens who follow the continuing international debate on the private–public mix in our health care systems.

Sonia Fleury holds an MA in sociology and a PhD in political science. She is currently a professor of public policy at the Fundação Getúlio Vargas in Brazil and was formerly a senior lecturer at the Institute for Social Development in Latin America of the Inter-American Development Bank. Dr Fleury is an expert in the field of social policy in Latin America and is the author of several books on the subject.

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